SOCIAL WORK PRACTICE, 1966

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The National Conference on Social Welfare

THE NATIONAL CONFERENCE ON SOCIAL WELFARE is a voluntary organization of individual and organizational members whose major function is to provide a national forum for the critical examination of basic problems and issues in the social welfare field.

These annual forums furnish a two-way channel of communication between paid and volunteer workers, between social welfare and allied fields, and between the service organizations and the social work profession.

Since 1874, through its annual forums and its comprehensive publications program, the National Conference has reflected the history and dynamic development of social welfare in this country. Its national office serves as headquarters for state conferences in social welfare; as the secretariat for the International Conference of Social Work; and as a clearinghouse for educational materials for use on a local, state, national, and international level.

Among the newer services developed by the Conference in recent years is its library of unpublished Annual Forum manuscripts; its Document Retrieval Program, including the data-processed production of the *KWIC Index* of its publications since 1874; and its Selected Bibliography Service.

Foreword

KNOWLEDGE AND SKILL ARE PREREQUISITES for working effectively with people and bringing about social change. One must possess knowledge and understanding of individuals, groups, and communities and the factors and forces which affect them. One must also have familiarity with the basic methods of working with individuals, groups, and communities and competence in using this know-how in relation to different needs and in a variety of settings.

The need for more knowledge and skill is never ending. However, equally important is the dissemination and evaluation of both old and new insights, experiences, and experiments. Through the 93d Annual Forum the National Conference on Social Welfare provided an excellent opportunity for the exchange of new facts, challenging ideas, and "practice wisdom."

This volume, *Social Work Practice, 1966,* includes papers dealing with the basic social work methods—casework, community organization, and group work—and their application in various agencies for the treatment and prevention of individual and social dysfunction and the enhancement of higher social functioning. *The Social Welfare Forum, 1966,* the companion volume, consists of other papers from the Forum which present and analyze the key trends, issues, programs, and proposals in social welfare and especially those related to "Social Welfare's Role in Economic Growth," which was the theme of the 1966 Annual Forum.

The first four papers in this practice volume deal in depth with each of the methods of social work. Meyer relates the casework method to the changing society. Gurin describes persistent issues in the community organization method and current attempts to

resolve them. The paper by Rothman and Papell and the one by Tropp explore the relationship of the group work method to the other social work methods. All four papers are evidence of the profession's efforts to evaluate knowledge and skill, to refine it and add to it, in order to deal with present and future problems and opportunities.

The other papers, arranged in alphabetical order by author's name, reflect the field's concern with refining old methods and finding new ways to deal with a variety of existing and emerging needs. The papers by Griswold (with Wiltse and Roberts), Miller, and Rolfe are concerned with the problems of illegitimacy, chronic illness, and bereavement respectively. Examples of new programs and methods of practice are given in the papers by Davis and Shellhase. The articles by Gil and Mayers highlight the insights of, and plans for, research which can improve practice.

The current interest and concern about the poverty program and manpower shortage are also represented among the papers in this year's volume on social work practice. King describes ways of treating delinquents from urban ghettos, and the paper by Morris is a case study of ways to involve the poor in programs on their behalf. The use of volunteers and nonprofessionals is described by Goldstein and Wheeler. The challenges which new needs, changing practice, and the differential use of staff pose for social work education are presented and analyzed by Kendall.

As in the past, it was not possible to include in one volume all the many interesting practice papers presented at the Conference. The Editorial Committee read every paper and considered each one carefully. All final selections were unanimous. Special efforts were made to choose papers that reflect new insights and innovative practice. When possible, priority was given to areas not frequently and recently covered in publications of the NCSW and to authors who are new or relatively infrequent contributors to the literature of the field.

I personally am most grateful to Mary Houk and Elinor Zaki who as members of the Editorial Committee helped make the difficult task of selection easy, challenging, and satisfying. Special

thanks are due to Hollis Vick, who on short notice agreed to substitute for Ruth Williams, whom illness prevented from providing staff service to the Committee, to Mrs. Dorothy M. Swart, representative of Columbia University Press and editor of this volume, and to Joe R. Hoffer and Mrs. Mabel Davis of the Conference staff, all of whom assisted the Committee in many important ways.

ARNULF M. PINS, *Chairman*
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Casework in a Changing Society

by CAROL H. MEYER

Social casework is an individualizing practice that has derived from many sources. It can be traced back to the philanthropic movement of at least fifty years ago, to the psychoanalytic theory that took hold forty years ago, to the social science theory that began to take effect ten years ago. Social casework is a most interesting creature of society; for it has constantly responded to the requirements of each era, modifying its practices and accommodating to the particular concerns of the period.

Social casework, as a method, is fifty years old, if we view it as starting with its systematization by Mary Richmond in 1916. Fifty years is not a short span of time for a method to have persisted, particularly in light of the upheavals in the world in this last half century. There are some demonstrable reasons for the method's continuance and, if the past tells us anything about the future, we can expect that casework will go on being useful in our ever changing society because it is by nature an adaptive process, not confined to any historical period.

For one thing, its theoretical base is so structured as to provide for new knowledge and techniques as these may evolve in any era; it is an *open* theoretical system. This means that the theory prescribes for thorough knowledge, understanding, assessment, and selective action in a variety of case situations within a psychosocial framework. It operates on the basis of knowledge of human behavior and society available at any given time. But it is not only knowledge that changes as it accrues, social conditions and social organizations too are continuously different. For example, the perception of family life has changed and along with it, theories of

family behavior. Note, for example, how the views of family life have changed from Mary Richmond's conception of it in the sociological terms of 1910, to the 1930 view of the family as an arena for the expression of individual libido, to the 1960 notion of the family as an interactional system. Changing theory has reflected the times, and social casework has generally accommodated its practices accordingly. This response to change, this particular characteristic of adaptability to new knowledge, has enlivened casework practice. The strongest evidence of this adaptability may be found in casework's present commitment to ego psychology as probably the most useful behavioral theory of today. We can recall casework's attachment to the emphasis on id psychology that was relevant to life in the 1930s and 1940s, and we can identify Mary Richmond's grounding in the behavioral psychology of fifty years ago. As for the future, I would assume that casework theory will be enriched, and modified as well, by the theories of human behavior that will evolve in the next twenty years. As for theories of society, today caseworkers have better tools for understanding society than were ever before available. Descriptive theories in sociology and anthropology, for example, have given way to dynamic theories of social systems, social change, culture conflict, and political processes. These theories are developing in the present. We do not need to wait for the future to make use of them.

Another reason for the continuing validity of casework theory is its sensitivity to the mores and conditions of society. As casework has evolved through these five decades, it has taken on the coloration of each of them, influenced by the values and circumstances of the day as well as by the accumulated knowledge of the period. I happen to find this chameleonlike characteristic quite congenial; for it indicates that as a creature of the times, as a major part of the institution of social work, social casework must indeed reflect the current social mode or cease to be part of an institution in society. Over the years, the mode has changed, reflecting the ever changing condition of man in this civilization. Today, perhaps we could identify several methods of practice because, like the individual who collects memorabilia of his past and finds it difficult to discard things that once were meaningful to him, social casework has not

shed its old, familiar habits, even as it has taken on new ones. Thus, modern practice is characterized by a range of modes which may still be appropriate in selected situations although in other instances they may be antiquated in the light of new conditions. Each period of history in this country has promoted a modified stance in casework practice, just as this period too is affecting that practice.

Each of these modes, evolving out of different eras, has been addressed to a particular kind of client, the worthy, the treatable, and the "workable," all of whom have been in some kind of trouble. Casework is an individualizing process. Consequently, it is undoubtedly useful to have a variety of practice methods from which to draw in order to meet the needs of clients. The thread that has unified all these approaches has been *service,* and they have all been used across cultural and class lines, with public and voluntary sanctions.

It seems to me that there have been three differentiating factors throughout the history of casework. One has been the client group served by the different modes of practice. This has changed along with the theoretical emphases. The second is the level of intervention, which has ranged from early to late in the continuum of social breakdown. As in the past, the definition of who is to be the client and when casework shall become operative must underlie the practice of the future. The third difference lies in how casework is practiced. It is in these three areas that we will find casework practice modifying its approach in order to keep in step with rapidly changing conditions. We know *what* it is, but who the client shall be, when casework shall be utilized, and how it shall be applied are questions that will find their answers in the requirements of modern society. If we affirm that it is not the theory of social casework that is in question but rather the uses to which it may be put, then we will have some hard decisions to make about its future direction.

Will the client group remain the worthy (as defined in 1966 terms), the treatable, or the "workable"? Will we continue to practice with those people who remain amenable to our methods, or will we seek out the public and attempt to adapt our methods

to the universal needs that are all about us? Perhaps there is no single "client group" any more; there is the community of people, not just those in the greatest jeopardy, those who are the most motivated, or those who are the least motivated. Individualizing casework services happen to be peculiarly fitted to the social conditions of our times, and if casework does not remain responsible to society's pressures, then society will seek help from other sources.

As to the level of intervention or the direction that casework practice will take, we are faced with clear alternatives. Will we wait for breakdown to occur and then provide the best treatment possible in clinic, court, or agency? Or will we assume responsibility for the public's psychosocial health and well-being and collaborate in new ways with existing social institutions to provide casework coverage within the community? Since clinics, courts, and agencies are of the fabric of the community, this would not rule out our staffing them, but so long as so many of us wait for the individual case to be made, and avoid the schools, the well-baby clinics, the housing complexes, the neighborhood service centers, the day-care centers, and all other institutions which are part of the normal, stressful life of the community, our help will be too little and too late. It would seem to follow that if the modern conception of "problem" is the chronic stress that is about us everywhere, then caseworkers will have to find some ways to provide coverage in institutional rather than in residual terms. While casework theory is valid and casework methods are adaptable, practice will prove to be socially dysfunctional if it continues to be applied to some clients and is not available for all people, provided under certain prescribed circumstances and under no others.

It has occurred to me that the trend in social casework has been quite the reverse from that in public health, and that now we might learn something quite important about the road toward public responsibility that public health has traveled. Casework is traveling that road now, seeking approaches to public psychosocial health. Casework is also confronted with the "diseases of civilization" found in family breakdown and loss of autonomy. It has been said that "the issue is not one of individual malfunction or inadequacy, but one of status which defines requirements and

needs." [1] Today, in other words, the mere fact of being a member of a family defines the need for role support and sustenance.

An almost inevitable conflict is integral to the status of family membership in this stressful society. It would be irresponsible for casework to assume that its services can be called upon only when the conflict between marital partners erupts, or when their children must be placed. If we agree that our mass society with its technical progress demands more from individuals to cope with it than we expected from people in previous eras, then we must expect trouble, look for it, and be there to help. There are no preventives for the chronic diseases known to medicine that are comparable to the vaccines developed to prevent communicable diseases. Likewise, in social work terms, because we do not have enough knowledge of causation, we have no prescribed preventives; we can only be where we are needed as early as possible and not leave so much to chance. Ultimately, we may learn how to step back even further in the interventive continuum and promote the strengthening of our society's institutions so that "normal" problems of living will not occur at all. Someday, perhaps, social workers will command the attention of the legislators and the community at large and insist upon social prerequisites, such as good housing, enriched school life, and provision of family-sustaining services, just as public health doctors insist upon sanitary laws and unpolluted air and water as health prerequisites. These social goals are broader than methodological concerns, but it would be a step toward professional responsibility for the public psychosocial health if we could activate our methods just a little earlier in the interventive scheme.

Today a dilemma faces us. Can we afford to wait for further pathology to be discovered? Do we even have the tools to treat the degree of pathology we confront today? Will society wait while we assign the many millions of people who need our services to the very few thousands of available caseworkers. Will we ever get our thumbs out of the dike? If we seek to move our practice back far-

[1] Alfred J. Kahn, "Therapy, Prevention and Developmental Provisions: a Social Work Strategy," in *Public Health Concepts in Social Work Education* (New York: Council on Work Education, 1962), pp. 132–48.

ther and to spread it further so that it will reach more people, we shall have to deal with certain modifications in our practice and take a hard look at some of our most familiar conventions. We will need to contemplate the validity of tested notions that have been deemed indispensable to modern practice even though they were devised in another era.

I mentioned that changes in casework method must reflect those taking place in society, so before we consider the implications for practice let us look at what is changing around us.

There are philosophies, books, plays, art, music, popular phrases, and technical concepts all about us, all saying something about our society. *The Lonely Crowd, The Organization Man,* bureaucracy, technocracy, cybernetics, automation, existentialism, isolation, depersonalization and mass media, for example, all flow together to create a particular image. Should it be described as man's meaninglessness? Technically, might it better be named man's loss of autonomy? Bruno Bettelheim wrote a book a few years ago whose title, *The Informed Heart: Autonomy in a Mass Age,* is almost as significant as its rich content. In his exposition of the problem of restricted autonomy Bettelheim says:

> The experience of growing vagueness about who one is, the sense of restricted autonomy, is fostered by modern mass society.
>
> . . . When social change is rapid, there is not enough time to develop the new attitudes needed for dealing with an ever-changing environment in terms of one's own personality. This makes the individual "confused" and uncertain.[2]

Thus, as Bettelheim describes it, rapid and acute changes in society create problems as well as opportunities for the individual. Just by virtue of his existence in a mass, technically advanced, and complicated society, the individual is faced with conditions that in and of themselves create special and very modern problems.

Of all the problems of our time, the loss of autonomy, of uniqueness, of individuality, is probably one of the most serious and most tragic. How do we see it expressed and what are its multiple causes?

[2] Bruno Bettelheim, *The Informed Heart: Autonomy in a Mass Age* (New York: Free Press of Glencoe, 1960).

Beginning with the simplest or most obvious problem that may be at once cause and effect of restricted autonomy, the sheer increase in population and its concomitant results have created the mass society and have restricted individuality. Urban living has brought with it inner cities, anonymity, tensions, overcrowding, pressing demands for all services, family bickering, and terrible loneliness. Resultant family breakdown without any of the natural social supports in the intimate sphere of the family's life has led to behavioral outbursts, marital conflict, child neglect and abuse.

Socialization, a process traditionally carried out by the family, is uncertain. Lines between right and wrong are blurred; role models are unsteady and out of focus, and Victorian dicta that created guilt and led to certainty and absolutism about behavioral standards no longer seem to be relevant. Education is a sometime thing, carried out in half-day sessions by overworked teachers for unmotivated students. "Facts" no longer are as true as they used to be, and the future for which today's child is being educated is no longer assured. Mass-reaction devices do not serve the individual except to estrange him further and to contribute to his loneliness. Even work, that concrete expression of puritan values, no longer has the same significance. Too often work is not available, and when it is, man is increasingly subjugated by machines and separated from his fellow worker as well as from his employer and the consumer of his services or craft. We have barely mentioned these intimate problems of man in our present society; we have not even cited the major problems, such as the threat of atomic warfare and the prevalence of poverty in the affluent society. Nor have we talked about the severe problems of illness, delinquency, narcotic addiction, and alcoholism; these are serious enough, but they are of a different order.

Population increases, technological changes, the physical and emotional stresses in modern living, along with the breakdown in social supports, all create a singular problem in our present society, in the way people live. Life itself has become a social problem, and one not amenable to a specific cure.

In public health terms, the medical "diseases" of civilization are heart disease, cancer, mental disorders, arthritis, diabetes, and acci-

dents. These are all pervasive conditions and surely reflect the pace, the stress, the tensions, and the deprivations of our society. Incidentally, there is no known specific for any of these diseases; they are perceived as being an aspect of society, not even ego-alien to society. In social work terms, it may be possible to state with some precision that our versions of the diseases of civilization are isolation and problems of identity as they are expressed in family and social breakdown. Perhaps these are the contagious diseases of our time, and perhaps they are not really curable. But they can be identified, worked with, and contained through reinforcement of social institutions and patterns of collaboration, through our identification with the mood of the people, as well as through direct treatment along a range of modalities.

There is a certain chronicity abroad. No longer do we have acute problems. There are social pressures, social injustices, social breakdowns; no longer do we have the tidy symptoms of neuroses. Examples of this phenomenon may be found in the caseloads of practitioners everywhere; we have already become cognizant of character-disordered clients with lifetime problems that are indeed ways of life and not merely pathological responses. The age of anxiety cuts across class and cultural lines; no one is immune to the pressures of our times, for we are all susceptible to the diseases of our civilization. I am not even sure that it is possible to place these diseases in a clinical frame of reference. What diagnostic classification would fit the desperation of a man with five children, living in an urban housing complex where every apartment is identical and his intimate life is controlled by a bureaucracy, who goes downtown to work in the social darkness of a vast organization, whose children attend overcrowded schools and whose wife tries to cope with the dirt and the supermarket and the endless impersonalities of her neighborhood life—assuming that she does not have to work in order to keep the bills paid? What clinical entity would describe the malaise of a physically healthy but thoroughly lonely and unproductive aged woman who has no relatives who care, because they live elsewhere or because they are too busy and unhappy themselves to be concerned about her? Where is the clinical evi-

dence of anomie? What is the prescribed cure for reality-based feelings of depersonalization and identity diffusion?

There is still another kind of change that has occurred in our society. It has to do with the civil rights movement, with protest, with widespread unrest that is finding expression in both organized and spontaneous social uprisings. The cause may be large or small, but increasingly demonstration by citizens is the form which the protest takes. Whether it be mothers marching on city hall to fight for a neighborhood traffic light, or students tearing up their draft cards, or parades for peace, or marches in Selma, Alabama, or the clamoring of the organized poor for participation in planning or for services, or the picket lines of welfare clients protesting low budgets, it is all of a piece. This is an age of a truly aroused and active citizenry that will no longer wait for the benefits that a privileged group is willing to disburse. The philanthropic motive once characteristic of social casework no longer is attuned to the mood of the people. This is an age of welfare for the public, an age of human rights, an age of civil liberties. Narrowly defined agency intake policies may clash with articulate demands for service. It is inevitable that the practice of casework will need to adapt to this change in mood and in power, as well as to the changing conditions in society.

Have social caseworkers kept up with the times? Why is it that Officer Kropky in *Westside Story* and the social worker in *The Thousand Clowns* draw such laughs from an audience? Do caseworkers really know what it means to be "beat," "cool," or "loose"? How many of us recognize the language in *Last Exit to Brooklyn* or *Manchild in the Promised Land?* Do we know what to say when an adolescent asks, "What's in it for me, man?" Do we recognize the potential development of strengths when one individual after another in a community wants to fight the system and "march on the welfare department" because the checks are slow in coming, or because "Mr. Charlie is doing me in"? Do caseworkers "handle" these "problems," or do they recognize them for what they are—a new voice in a new era, a new spirit in a changing society?

In view of these changing circumstances, it seems that people will not stand still and wait for us; nor will they accommodate themselves to translating their discontent and malaise into clinical entities. Moreover, as it has become clearer that individual problems are intricately woven into the fabric of the social scene and that every psychosocial phenomenon is related to everything else, these new combinations of problems and forces must have a profound effect upon social casework practice. Schwartz and Schwartz comment:

> When practitioners discuss broadening the conceptions of help, directly or by implication, what they are doing is altering a number of notions related to the process of helping; that is, they are concerned with ways of re-conceptualizing the unit of help, changing the definition of patient and object of help, expanding the role of helper, and re-orienting their approach to help processes.[3]

Are we to put our greatest effort into primary prevention? Or are we to continue to select the voluntary, motivated clients with whom we will work, on the erroneous assumption that theirs are isolated problems? Will we continue to see clients as cases rather than as citizens and members of the community? Will we learn how to practice our well-founded social casework in new ways, with more personnel, more effectively and realistically? The major question is: Will social caseworkers assume a new sense of responsibility toward the public and its psychosocial health? Assuming that the choice is inevitable, that our profession will have to take a significant position, and that casework probably more than any other social work method is in a position to demonstrate how that can be done, there will be profound implications to consider.

There are concepts and principles, practices and organizational arrangements that will have to be perceived differently, so as to adapt casework practice to the social scene. This process of modification is not new to social casework; as I have taken some pains to point out, it is just this capacity to change that has kept casework practice alive these past fifty years. I believe that this ability to modify practice exists today as it has throughout our rather mar-

[3] Morris S. Schwartz and Charlotte Green Schwartz, *Social Approaches to Mental Patient Care* (New York: Columbia University Press, 1963), p. 85.

velous history. One aspect of our practice has not changed and, as a matter of fact, seems to be the guiding force that makes casework modern in every era. That is the value system which is at its core.

These values are so fundamental to our society as well as to social casework that if they were to change, our social structure would be completely different. They are rooted, as Gordon Hamilton has said repeatedly, in democratic, Judaeo-Christian morality and have to do with acceptance of people, respect for their right to individual differences, regard for the worthwhileness of people as people and not as pawns to be manipulated by the state or any group, and regard for the rights of individuals to have equal opportunities to develop their unique potentialities.

But what modifications will have to be made in casework practice? Some basic concepts and guiding principles might be reexamined, not only to assess their relative nature and current applicability, but also to guard against their distortions. For example, there are organizational structures and principles in practice that are mutually contradictory and have to be reconciled, as well as basic assumptions which are still valid but perhaps not implemented, or implementable, under current conditions. Reevaluation of these concepts ultimately will lead to changes in traditional techniques. Let us look at a few of our "favored notions" and try to evaluate their current validity.

The most important structural question has to do with the location and functional organization of social agencies. If the full range of casework services is to be provided for the public, to be available when needed to shore up social institutions and at times of stress, then it will be difficult indeed to reconcile our present arrangement of agencies. Are these as appropriate as they once were? Early in social work history, members of a community devised an agency program when they became concerned about a particular client group or a specific community problem. As a part of voluntary movements, social agencies could functionalize their programs and offer help to those whom they could or would help, leaving to other agencies the task of aiding those who did not fit into their structures. Thus, today we have a proliferation of such

agencies, each with its specialty and traditions. The profession of social work has even dignified these programs of specialized services by the appellation "fields of practice." Is this a dysfunctional concept in considering the pervasiveness and interrelatedness of our social problems? And will the location of a well-endowed "uptown office," serving a specified client group or a particular problem constellation, be as meaningful so far as coverage and presence are concerned as would neighborhood service centers based in the community and all around the town as part of the life and culture of the people they serve?

Pursuant to the idea of community coverage and public responsibility, casework must look again at its manpower situation. Since only 21 percent of the current number of 105,000 social workers are trained,[4] there is no turning aside from the reality. Caseworkers, the particular group that is supposedly expert in helping clients to deal with reality, seem to be having the most trouble with this notion. If we agree that the casework services which we value so highly are to be brought to all the people who need them now and who might need them tomorrow, then we will have no choice, no alternative at all in reality, but to continue ways to utilize wisely masses of personnel of all types who could not conceivably be educated for a professional role in 64 or even 104 schools of social work within the next 40 years.[5] There is a wide spectrum within which there is room for practice on a variety of levels. In case finding, for example, volunteers and case aides could be used to full advantage, and it is within comprehension to imagine a nonprofessional career technician in social casework roaming through a public housing complex, giving advice about where to obtain health and welfare services, serving as receptionist in a well-baby or maternity clinic, or helping to identify psychosocial need and—under a professional's guidance—helping to relieve pressures. The list of possible tasks is enormous, and our examination of old modes in light of current demands would not be complete without consideration of new ways to utilize untrained manpower.

[4] Mary Baker, "Personnel in Social Work," *Encyclopedia of Social Work* (New York: National Association of Social Workers, 1965). p. 538.

[5] Carol H. Meyer, *Staff Development in Public Welfare Agencies* (New York: Columbia University Press, 1966), p. 13.

Then there are concepts and principles underlying casework practice which may have to be perceived a little differently; for they were developed in another period when life was different and when social casework had a less important role in the institutions of society.

One example is the concept of motivation as a determinant of casework help. Motivation as a concept is based upon felt need, which in itself requires that the individual have a clear sense of feeling troubled. Is this as common now when trouble, pressure, stress, anomie, and malaise are in the air and are not alien to the individual's ego? Moreover, with our present knowledge of ego psychology, our theory is way ahead of our old commitment to motivation. We can ascertain where functioning is impaired and, being obligated to offer services, we can reach out to make our service meaningful without having to rely upon client motivation. Caseworkers' emphasis upon working with motivated clients has restricted their activity. Lately, a change has already occurred since workers are reaching out and finding cases that would not come voluntarily for help. Motivation in clients is helpful to a caseworker, but it does seem to be outmoded as a major criterion. The very condition of loss of autonomy would suggest that individuals in our society are not aware of who they are, and thus they succumb to stress without the degree of conflict that previously motivated them to seek assistance. Most important, we need to be sure that we do not misuse the concept of motivation in a subtle way so that we will neglect giving service to people who do not seek it.

Also, there are practices favored by social caseworkers which came out of another era and may not work as well today. For example, total reliance on the one-to-one interview served well when practice was preoccupied with relationship and transference. This is not to say that relationship is not a significant tool in treatment, that transference does not occur, or that many people do not require a one-to-one relationship. This mode will be used as long as individuals have individual problems. However, new knowledge about group and family treatment has evolved and ought to be recognized, and some goals of casework may change so that the

one-to-one interview may not continue to be a prerequisite of casework. Today we are closer to conceptualizations that will more closely fit our actual method of practice.

Another traditional practice that bears reexamination is our total reliance upon the clinical context. This does not mean that clinical knowledge is outdated; it means only that it must be enriched by new knowledge and expanding views of the person-in-situation. Let us refer back to the family whose problems rest in their very existence in this troubled world. The question was raised as to what clinical framework the family members could be placed in, because their interactions with each other and with the social institutions and forces in the community defy a single classification scheme or nosology. There are many variables in every case, and we must seek a way to put them together; for they are transactional entities and are dynamically interrelated, not linear to each other. For example, along with behavioral manifestations, there are in any family members at different age levels, each with its tasks to be accomplished, according to Erikson's concept of ego identity. There are sex variables, each related to specified role concepts defined by the culture and by the individual himself. There are interactional components to be identified as they operate among family members, as each member reacts to, and acts upon, the others, while at the same time each member, and the family as a whole, is in dynamic transaction with social forces. Thus, we may call upon social system theory to explain the "case," which by now has become quite a bit larger than the individual person. Pursuing this approach to conceptualizations about our expanding unit of attention, we find theories of social change and bureaucratic structure, for example, that would serve us in understanding the stress and potential helps for the family related to the real work, outside as well as inside their home.

Reexamination of some of our practices suggests that we ought to reconsider the idea of the weekly fifty-minute "hour," or any other static view of timing in practice. If caseworkers are to provide help on the spot, wherever they observe need, it may take ten minutes or twenty-four hours once a week, four times a week, or twice a year. While an appointment may also take just fifty

minutes, the time should derive from the needs of a case and should not be arrived at arbitrarily. The exclusive use of the "hour" made more sense when cases were thought to be curable and were treated along clinical lines, but does it have the same significance now when chronicity is the hallmark of so many social problems? This practice construct has forced us into the position of talking about long-term *vs.* short-term treatment, which I cannot accept at all. It seems to me that short-term treatment, when viewed in this way, is merely a kind of reaction formation against the idea of long-term treatment. Both short- and long-term treatment, when used appropriately and differentially, would more nearly meet expectations of client need.

Lucille Austin says that "short-term treatment has been discussed chiefly as a matter of expedience; seldom has it been recommended as the treatment of choice." [6] It seems to me that this approach would be more appropriate.

Thus, our goals will determine the length of treatment. If we use casework as primarily intensively practiced therapy, a counseling service that is directed through the treatment relationship to "not quite, but almost" personality change, then it will take a long time indeed. This goal would require the familiar ingredients of motivated clients who are in sufficient conflict, who possess fairly well-integrated egos, who are sufficiently socialized to want and to use treatment, who are educated enough to participate in verbal communication, who can contain their problems until the once-a-week fifty-minute hour, who have the internal and external resources to tolerate the anxiety that accompanies treatment, and who have the strength, carfare, and baby-sitters to seek it out.

On the other hand, if we envision casework as a community-wide and community-felt service, sometimes—as need would determine—having long-term goals, there is also available a host of ego-adaptive goals that include behavioral change, increased gratification from intimate relationships, and improved social functioning. If casework is to be the helping method of choice for people in crisis situations, there will be no particular value ascribed to the suc-

[6] Howard J. Parad, ed., *Crisis Intervention: Selected Readings* (New York: Family Service Association of America, 1965), Foreword, p. xi.

cessful closing of cases. Is there really a cure for social stress? Is there ever an end, after all? Why have we never viewed ourselves as simply available—like neighborhood doctors, perhaps—to help when there is trouble and even to move into situations before trouble appears? There does not seem to be anything antithetical to sound and excellent casework practice in the idea of helping, intermitting, and helping again, if that is necessary. After all, life in this modern world is characterized by chronic tensions that lead to chronic problems. Perhaps the answer lies in social casework being more geared to the public's life style, which is full of dangers, than to playing out traditional, parochial practices.

There is another practice mode that will have to change along with a changing focus in social casework, and that is the notion of social distance, which earlier derived from structured office visits and formal relationships conceived from the therapist-patient or worker-client roles. If caseworkers come to consider their patients as fellow citizens, and if they go out into the streets and the neighborhoods, there will be a great lessening of the traditionally sought-for social distance. Moreover, if a new goal in social casework is to be perceived as the relieving of stress and the strengthening of coping capacities, then caseworkers might begin to pursue a more political model of help. For what greater success in coping is there than for an individual to master his own environment? If casework accepts this as a goal in practice, then social distance will become even more alien as a concept when caseworkers encourage their clients to affirm their rights in the community and even join with them to accomplish that goal.

It is now evident that social casework must use its inner-outer, psychosocial construct more meaningfully. Both aspects of human life have taken on many new meanings. Psychologically, the term "intrapsychic conflict" has been expanded to mean developmental tasks, and "resolution of conflict" to mean ego adaptation. Socially, the environment has changed in conception from the framework in which the individual rests to the dynamic expression of his relationships, his areas of functioning, and his pathways to fulfillment. Taken together, the modern conception of "psychosocial" must include the individual as part of other individuals in

broader and broader connections, so that the caseworker will organize his helping role to be primarily one of intervening in behalf of the person and society as a unit which even includes the worker himself and the agency's structure. This "omnicon" concept [7] that includes psychosocial transactions is yet to become operational in our practice. Yet, I am quite convinced that it will be a significant theoretical formulation that will enable caseworkers to carry out their particular role in the future.

Society always changes, and social casework has always adapted itself to the current scene. So, today once again we have to utilize casework's inherent quality of adaptability in application. I am not suggesting that we remove the "clinical" from casework, or that we "put in the social." I am saying that both are intrinsic to social casework, and that knowledge must be used and increased; principles must be reexamined in the light of social conditions and resources and resultant expectations and goals; and techniques must be developed in line with new knowledge, conditions, and goals. It is self-evident that our practices must be modified, for they date back to a time when there was a different kind of knowledge, a different level of stress, a lower decibel count in the city, and a different spirit expressed by people everywhere.

I am not certain that caseworkers will be able to choose their role in any event. Society must inevitably find or devise some system, service, or program—some profession, perhaps—to meet psychosocial need on a vast scale in the community. Social work, after all, is an organized effort of society to do just that. Organized medicine faced up to this fact when it adjusted to Medicare. As society sees it, there is need on the one hand, and on the other hand there is a professional practice that describes itself as "social casework." It seems to me that the uses to which we put casework will come out of our commitment to the real world and to ourselves as knowledgeable practitioners who feel committed to rise to the challenge.

[7] Stanley H. Cath, "Some Dynamics of the Middle and Later Years," *ibid.*, pp. 174–90.

Current Issues in Community Organization Practice and Education[1]

by ARNOLD GURIN

THE COMMUNITY ORGANIZATION CURRICULUM DEVELOPMENT PROJECT of the Council on Social Work Education grew out of the turbulent changes which are taking place in the field of social welfare. It also grew out of a history of important change within the field of social work education itself. The project has assumed the formidable task of helping to prepare a new generation of professional workers to deal more effectively with these changes and with others which we know will occur although we cannot predict their precise nature.

The Curriculum Project reflects the convergence of two major developments. On the practice side it came about as the result of the rapidly accelerating demand for personnel in community planning and action programs. There had been shortages of long standing in voluntary agencies concerned with neighborhood organization and the coordination and planning of health and welfare services. These were intensified by the great expansion of governmental programs through the demonstration projects of the President's Committee on Juvenile Delinquency, the Office of Economic Opportunity (OEO), and the development of many different approaches to more comprehensive community service programs in all fields—health, mental health and retardation, re-

[1] Appreciation is expressed to my colleagues on the Community Organization Curriculum Development Project—David Jones, Wyatt C. Jones, Joan Levin, Robert Perlman, and Arnulf M. Pins—for their comments on this paper and for the work on which it reports.

habilitation, and public welfare, among others. It has been demonstrated very clearly in the past few years that the quantitative and qualitative lack in the personnel to plan and administer these programs is a major impediment to their effectiveness.

The parallel development in social work education was the emergence during the 1950s of community organization as a method of concentration in schools of social work, and the establishment of community organization on the basis of equal parity with casework and group work in the curriculum policy statement of the Council in 1962.

Specifically, the President's Committee invited a group of social work educators and practitioners in community organization to develop a plan for improving the curriculum and thereby helping to solve the personnel situation. The initial meeting was held in the spring of 1963, which seems a very long time ago indeed in view of the swift pace of change in the intervening years. The group submitted a proposal which was then implemented by the Council on Social Work Education. (It was agreed from the outset that the Council was the appropriate agency to conduct the project since it represents all the schools of social work as well as the major agencies dependent on the schools for professional personnel.) The Council was awarded a planning grant by the Office of Juvenile Delinquency to explore and design a curriculum project, and the project itself was finally organized, staffed, and began its three-year developmental task in June, 1965.

There are several interesting and unusual aspects to the organizational framework of the project. A rare exception in the pattern of training programs developed by the newer government agencies, it is a long-range investment in basic professional education. This is in contrast with the almost universal pattern of emphasizing the short-range in-service training that is mostly intended for nonprofessionals.

Another unusual feature is the relationship between the Council and Brandeis University in carrying out the research. In contrast with the general curriculum study of some years ago where a short-term staff worked in the Council office, the major staff work in the Community Organization Curriculum Development Proj-

ect has been subcontracted to the Florence Heller Graduate School for Advanced Studies in Social Welfare at Brandeis University. The decision to do so was made initially as a practical matter, but experience has indicated that the arrangement has very real advantages. The university is geared to the world of grants and short-term projects and can offer researchers and educators some assurance of continuty in employment, as well as teaching opportunities and contact with students. Consequently, a small staff of very high quality with a combination of skills in social research, social work education, social science theory, and community organization practice was secured. On the other hand, the location of the project's headquarters in the Council office, with Dr. Arnulf Pins, Associate Director of the Council, serving as Associate Director of the project, assures effective coordination of the project with the needs of the field and with other developments in social work education.

Another important element in the organizational framework is the advisory committee, a group of some thirty people from social work education and the fields of social welfare which need community organization personnel. This committee, under the chairmanship of Alfred Kahn, of the Columbia University School of Social Work, includes top administrators from governmental and voluntary agencies as well as from major coordinating bodies, such as the National Social Welfare Assembly and United Community Funds and Councils. It has been an active committee, contributing substantially to the development of plans and guiding the choice of approaches and priorities. There is keen awareness on the part of everyone associated with the Project of the importance of constantly maintaining effective communication with its ultimate consumers.

Most people do not realize how far the schools have actually gone in preparing people for community organization and how rapidly this area of their work is growing. Just a few short years ago, there were virtually no programs of concentration in this field, and a mere handful of students were participating in the few sequences that did exist. Today, twenty schools of social work offer a two-year concentration in community organization, ten offer a one-

year concentration, and a number of others provide at least a few field work placements. All in all, as of the academic year 1965–1966, there are almost five hundred students receiving field work instruction in community organization in a wide variety of agency settings. The enrollment in community organization concentrations has increased by 400 percent in the past five years, compared with an over-all increase in total enrollment of 55 percent. While it is true that community organization students still represent only 5.5 percent of the total, if present trends continue we may soon find that a very sizable proportion of all students in schools of social work are heading toward careers in community organization.

These encouraging trends are, of course, a great spur to the enthusiasm of our staff and give us the courage to struggle with the extremely complex problems of how to define and structure the curriculum content of the community organization concentration.

The general approach which we have been using in carrying out our assignment is to guide the development of the curriculum by an examination of the actual problems of community organization practice. We are not attempting to make a comprehensive, systematic study of the field. Not only is this beyond the capacities of our small staff, but it would not really serve the purposes we have in mind. The task with which we are charged is not to base a curriculum on what is now being done, but, more importantly, to determine what needs to be done and to help prepare people to do better. The curriculum will be developed on the basis of our best judgment as to the theoretical framework and principles of practice which should guide the practitioner, but these, in turn, must be based upon a realistic empirical analysis of the problems and conditions to which that practice will be directed. We have therefore been conducting extensive field studies, visiting a variety of public and voluntary agencies at the local, state, and national level. We are also conducting systematic interviews with selected samples of practitioners, students, and faculty.

Out of this activity are gradually emerging a number of major themes, relating both to the problems of practice and to education for practice. Our general plan for the second year of the proj-

ect is to deal with these themes through several monographs, each of which will represent a composite of practice principles, theoretical background, and case illustrations in a particular area of practice. We hope in this manner to conceptualize and clarify major elements of the curriculum content. The third year will then be devoted to the development of specific recommendations for the educational program itself, including such matters as: qualifications and prerequisites for admission to community organization programs in graduate schools; courses and sequences that should constitute the community organization concentration; the relationship between this concentration and other aspects of the curriculum; the relationship between class and field instruction; and the many other issues that go into curriculum construction. Although our major responsibility is for the graduate curriculum—that is, the master's degree program—we shall also try to make some recommendations in regard to undergraduate education and short-term in-service training programs. We are also concerned with clarifying the community organization content that is needed by *all* social work students, that is, those concentrating in other methods as well.

In the realm of values the Curriculum Project is an integral part of the social work profession's current reappraisal of its social responsibility and its effectiveness in fulfilling that responsibility. The focus today is inevitably upon the accumulated social ills of our society and, more specifically, upon the unsolved problems of the most deprived sections of the population.

A new image of social work is developing, due largely to the recent programs of social action in low-income areas. Among the entering students, those who are not interested primarily in clinical practice tend, for the most part, to be radical and change-oriented in their social and political outlook and are seeking to express these motivations through professional social work. Despite the many attacks on the social work "establishment," the presence of social workers in social action programs has apparently given these new students encouragement to believe that professional training is not incompatible with participation in social change.

What should the schools do with and for these students? Should

they "brainwash" the radicalism out of them? Should they teach them that the organization sets the objectives, and that they must learn to function within agency limitations? Or should the schools encourage and reinforce their militancy and instill it in those who may lack adequate ardor for the improvement of social conditions? All might agree that the schools should foster both disciplined professionalism and a strong sense of indignation against the evils of society. However, translating this dual purpose into a real program poses many practical issues that are hard to resolve. One of the most important and difficult problems is that students are placed for field work training in a wide variety of agencies with very different points of view—from Alinsky-type conflict-oriented organizations to governmental agencies or planning bodies that represent the authorities against whom most of the conflict organizations direct their action. Some have suggested that the schools should choose among such organizations either "establishment" or "outsider" organizations but not try to use both. Most schools, however, place students in settings that represent the full gamut of approaches to community conflict and social action. Should the schools then leave it to each agency to indocrinate their students with its position, or should they try to transmit an overall set of values that the students will carry with them into whatever field they enter after graduation?

Somewhat related to this issue is the question of who should give the training. As the number of community organization students grows so rapidly, the problem of finding suitable field placements and field instructors is becoming increasingly difficult to solve. We are seeing a great diversification of settings for field instruction. Students are being placed today not only in welfare councils and settlement houses but in mayors' offices, housing authorities, urban renewal agencies, with congressmen, state legislators, and city councilmen. This is part and parcel of the broader conception of what community organization in social work is and should be. Many of these settings obviously do not have trained social workers. Orientation to social work values will therefore have to come increasingly from the schools themselves. There is a growing pattern of field work units in which an instructor who is not

an agency employee but a member of the school faculty supervises a group of students working in an agency that is not, strictly speaking, a social work agency and may have no social workers on its staff. This is one way of solving the dual-loyalty problem. It may be uncomfortable for some of the agencies, but it does accomplish the purpose of helping the students to develop an identity and a value system that are not agency-bound.

Just what the value system should be and how it is acquired is far from clear. There seems to be more and more agreement that the central concept in the social work value system of self-determination is not adequate because it smacks too much of ethical neutrality; and that aggressiveness in attacking social injustice is equally vital. The field is still searching for a way of reconciling these two value commitments and is, for the most part, still convinced that they are reconcilable. There is also general agreement that the schools must provide some exposure to the nature of social problems as they present themselves in the lives of deprived populations, and to the cumulative force with which they determine peoples' lives. Within this framework there are undoubtedly many equally useful ways to develop a point of view that is motivated toward greater social justice and change efforts to achieve it, and the Curriculum Project is exploring as many of them as it can encompass.

It is clear that the community organization social worker of 1966 needs to know a great deal more than has been taught in a school of social work, and perhaps more than any school will ever be able to teach. The demands, as we discover in our field studies, are quite staggering, but there do seem to be some priorities. The chief recurring comment is that it is necessary to equip the community organization worker with a better understanding of the major community forces that he will encounter, and, particularly, that he be sophisticated in his understanding of politics. Whether the point of view is that of the militant social actionist or the social welfare planner, all seem to recognize that social welfare programs today are deeply interrelated with the political forces in the community, and a professional who does not know his way within that system proceeds at his own peril.

This need has been reflected in the widespread use in community organization courses of the works of Banfield and other political scientists who have developed conceptions and theories about the nature of contemporary urban politics as the interaction of a plurality of interests. Such notions have helped to make more sophisticated the knowledge base of social planners and community organizers in instituting planning structures and in developing strategies for the achievement of program objectives.

Equally important in preparing the future practitioner is an understanding that organizations are interconnected systems of functional relationships in which there are both opportunities and constraints that must be taken into account if an action program is to achieve its objectives. Sociology and social psychology play a much greater role in the education of community organization workers than they did ten or even five years ago, but we are just beginning to probe the precise connections between theory and practice.

The social science "kick" in social work education, particularly as it affects community organization, has aroused a certain amount of uneasiness in the world of practice, some of which is justified. Social science formulations when applied to action problems frequently seem to be totally irrelevant, or else they are fancy ways of stating familiar truths. The expert practitioner frequently knows in his bones the dynamics which the social scientist is trying to conceptualize. Social science knowledge is itself still in a primitive state, its concepts fragmented and often unclear, its findings uncertain. Yet thoughtful practitioners seem to agree that the answer is not less social science, but more and better development of theory in order to strengthen the base for understanding and transmitting the insights which come from practice.

Social work education is set unalterably in the direction of working on the development of practice theory through the collaboration of social scientists and practitioners and through training growing numbers of people who will have a firm grounding in both areas.

This attempt at closer integration of theory and practice is a central task of the project. As we review the current educational

programs, we find that many social science concepts are taught, but that the precise implications for specific practice issues are not always clearly spelled out. Our hope is to reorganize these areas of knowledge in a way that will relate specific theoretical concepts and research findings to the specific areas of practice to which they are applicable. For example, concepts of community power structure may be very relevant in central city-wide planning in urban renewal or antipoverty programing, but not so useful in working with neighborhood groups, where the concepts of group dynamics may be much more pertinent. It is this differential and focused use of social science materials which we hope to advance.

In addition, there are other areas of knowledge, as yet inadequately represented in social work schools, that are vital to future community organization practitioners and social planners. The greatest gap is in the field of economics. As we become more involved with, and more committed to, social change, it becomes ever more evident that the locus for large-scale change is primarily in the economic system. The frustration that has resulted from a large increase in programs to train people for insufficient economic opportunities has served as a reminder that the ability of people to participate satisfactorily in our society is primarily a function of economic conditions. We are in a period very similar to the 1930s in that social welfare and economic conditions are intimately interrelated, and what happens in one sphere has a direct impact on the other.

To the extent that the social work student learns anything about economics today, and he learns very little, he obtains that knowledge in the courses on social policy. We have recognized in the Curriculum Project that community organization and social policy are closely related and that the training of the kind of community organization social worker that we have in mind must include a strong component of social policy knowledge. So far, social policy courses have dealt almost exclusively with the field of social welfare. They have been courses in the history and current status of health and welfare services, with an analysis of current problems, trends, and social policy issues. But developments in the field are moving very quickly beyond this framework. Social planning is

taking place in a much broader arena, of which social welfare is one part, along with physical planning, employment, education, housing, and more. New terms are being invented to capture this rapidly accelerating and constantly broadening-out process, so that we talk today of social development, human resources development, urban planning, and the like.

There has been a great deal of tortured discussion in seeking a new and appropriate definition of social welfare and its specific responsibilities. In my opinion, it is premature and unwise to settle upon a firm definition at this time. The situation is too fluid, the needs too great, and the availability of personnel too limited for society and for the field of social welfare to afford the luxury of neat boundaries. Social workers are involved and will be used to the extent that they can function effectively. The issue for social work education is how to prepare them to function effectively.

Knowledge of social policy in its broadest sense and knowledge of the workings of the economic system as it affects and is affected by social policy alternatives are essential components in the preparation of the social worker of the future. We are merely beginning to develop this area and the tools that go with it, such as quantitative, computerized methods to measure social needs, costs, and effectiveness.

Finally, we must deal with methods and skills, for the ultimate test of the educational program is in the ability of the practitioner to act effectively. He must have knowledge and values, but these alone will be of no avail if he lacks skill in implementing them. In the past, the teaching of community organization has been thought of almost exclusively as a matter of method and techniques. Its place in the curriculum structure of the social work schools has been as part of the methods sequence, along with casework and group work. Today, we are planning the curriculum more broadly, placing a considerable degree of emphasis upon building a more coherent body of knowledge to undergird practice.

The key to our approach to the development of method is to think about multiple methods of community organization practice rather than a single method. For a long time, teaching in this field

has been bounded rather rigidly by the model of the enabler. More recently, the pendulum has swung toward a different kind of model, that of the expert planner. As is typical of a changing, developing field, these models have sometimes been considered mutually exclusive alternatives. Our field studies have produced voluminous evidence that both roles are needed, but not always at the same time and the same place. The challenging problem, on which we have made a bare beginning, is to define more clearly the specific conditions under which one or another or still other types of practice are appropriate. The skill we shall need in the practitioner of the future is the skill of making a situational diagnosis and analysis that will lead him to a proper choice of the methods most appropriate to the particular task at hand. He should know, for example, when the formulation of a proposed plan is needed to advance a process and when it will impede the establishment of enough consensus to permit *any* type of planning process.

Fortunately, a number of significant contributions have been made in the development of such practice theories, and more is being done every day, so that the Curriculum Project has many useful insights to draw upon and to test against its findings in the field. Within each model of practice we shall try to spell out the specific skills called for and suggest effective ways of learning them. The basic enabling skills that social workers have learned in the past, which involve the ability to help people formulate objectives and move toward their implementation through a guided process of interaction, will continue to occupy an important and, indeed, central place in this training. But in this more sophisticated era we should be able to provide much more content even within that traditional approach. For example, there is an ever greater need for methods of measuring needs and analyzing problems with the emphasis on the problems and their possible solution rather than on the study process itself as a way of achieving consensus. There is tremendous need for skill in program development, in the translation of general objectives and policies into step-by-step program realities. This demands not only program knowledge, but skill in administration, budgeting, and financing, as well

as sophistication in the politics of organizations and skill in negotiation.

If we take the pluralistic rather than the monolithic approach to the community organization field, it is obvious that the educational program must be flexible, comprehensive, and varied. Our curriculum will have to be built around a core and provide many options. Not everyone can be expert in everything. There is already a development in existing programs of areas of subconcentration within the general community organization concentration. Some focus more heavily on neighborhood organization and social action; others, on social welfare planning and coordination. To a very minor degree—but this is bound to increase—some few students are beginning to emerge as social policy analysts and social planners.

In the community organization curriculum, as in social work education generally, there is a perennial dilemma between the generic and the specialized. Skill requires specialization, yet progress and innovation can be hampered by overspecialization. In response to our questions as to what attributes are most desirable in practitioners, agency administrators almost invariably stress flexibility as an essential quality and seem to prefer the skills of analysis, organization, and negotiation rather than knowledge of specific content areas. Our general view at this point is to place the emphasis on these basic skills and, at the same time, to help students understand as broadly as possible the community and society in which they will be functioning. They will all be doing different things and will have different agency responsibilities. It is our hope that they will have some ability to communicate, because their education will have been based at least to some extent on a common body of knowledge and a common set of values.

Group Work's Contribution to a Common Method

by CATHERINE PAPELL and BEULAH ROTHMAN

THE MOVEMENT toward greater flexibility in the use of the several social work methods is already a reality. We hold new conceptions of how service should be delivered which oblige us to move out where the problems are and to offer service through several avenues. We have reached a point in the development of the profession where significant numbers of practitioners have acquired a breadth of knowledge and skill that makes possible their utilizing any one of the several social work methods. These practitioners, no longer limited by an obsessive preoccupation with one method, move freely and creatively to innovate and to explore new variations on practice modalities.

Social work education must likewise respond to the changing and innovating aspects of the profession while at the same time it remains faithful to its charge to prepare persons to enter the profession. We are more and more aware that in today's market new graduates begin their careers in positions where the service offered represents a fusion of methods. The new practitioner is often confronted simultaneously with responsibility both for determining and for embodying the skill needed in working with individual, group, or community. Thus social work education, while holding to its time-honored concepts, must search for higher levels of generalization in order to transmit more economically the knowledge base for multiple skills. The strain toward identification of common concepts and theoretical unity among the several methods

of social work is shared by social work education with the profession as a whole.

Conceptions of adaptability of competence, multiplicity of service, and commonality of constructs bring into focus the question of the relationship between the methods and whether there is, in fact, a single rubric under which they can be subsumed or unified.

Several group work writers have been concerned with this question. At one polarity is William Schwartz, who states that

> the task of safguarding the uniqueness of the various so-called methods fades before the real problem of abstracting from all these experiences the common methodological component of the helping process in social work.
>
> . . . the moment has passed for a definition of "group work method." . . . The job can no longer be done most usefully by first defining social group work (or casework or community organization) and then trying to fit the description into the general framework of helping theory. The process is now rather the reverse: by laying the groundwork in a social work methodology, we may begin to analyze and clarify the activities of the social worker as he works with people in groups.[1]

In contraposition is the view of Emanuel Tropp:

> In view of the untouched segments of knowledge and skill which still have to be absorbed to attain mastery in group work, the concept of a unified method or a combined competence in two methods can only serve to dilute the professional functions of both methods even further.
>
> Group work will mature (and all social work will gain) when it distills and codifies the principles waiting to be drawn from its own experience, when it renews its contact with the social sciences, when it absorbs new concepts from relevant sources and integrates this knowledge into its own unique theory and method.[2]

The positions of Schwartz and Tropp appear to be unreconcilable. The choice of one over the other leaves us with a sense of uneasiness and incompleteness. If we follow that formulation which focuses solely on the distinctive and unique attributes of each method, we seem to fly in the face of common sense as well as of

[1] William Schwartz, "The Social Worker in the Group," in *The Social Welfare Forum, 1961* (New York: Columbia University Press, 1961), pp. 149–50.

[2] Emanuel Tropp, "Group Intent and Group Structure: Essential Criteria for Group Work Practice," *Journal of Jewish Communal Service,* XLI (1965), 249.

historical tradition. That there is commonality has already been identified, but there is no reason to believe that such commonality has been fully explored. As a matter of fact, present evidence would seem to support the notion that we are only at the threshold of a new generic dimension. We need to establish and increase the common factors of practice that are present in all the helping processes. If the profession of social work is to be accepted in the society of professions, it must identify its core base of practice as well as its core base of values and knowledge. Focusing solely on the uniqueness of each method, moreover, creates redundancy in the social work curriculum and obstructs the inclusion of new knowledge.

On the other hand, the exclusive pursuit of a common method, while somewhat seductive, seems also to be fraught with risks. The methods have evolved differentially and have historically been designed to deal with particular problems. At this stage in the development of the methods our perceptions of similarity may be limited. A common method may be in itself a merger, but at a level of oversimplification which is not representative of the advanced knowledge and technology of any single method. Or commonality could produce constructs at a level of abstraction that obscures specificity of application.

What theoretical tools can help us to move out of this impasse and onto a more tenable position which encourages experimentation and at the same time holds us to disciplined purpose and action?

We find that a systemic formulation is one reasonable guide out of the predicament of polarity. We are reminded by this formulation that forces of integration and differentiation, wholeness and separateness, are coexistent in any system. We have but to look at the history of the generic-specific construct in our own profession to find evidence of this dynamic. When priority was given to similarity in the fields of practice in order to achieve a generic base, the specific did not disappear. It insisted upon being reaffirmed at new levels. The structural changes in our professional association are illustrative as is the changing emphasis in the corrections field. Acceptance of this field by our profession came about through as-

sertion of the applicability of the generic to it. Later, through re-examination of its special dimensions, new approaches to practice in the corrections field emerged. One can trace the circularity from unity to specificity and back to unity in the writings of Elliot Studt. To expect that social work methods would be any less subject to these systemic laws defies common sense.

Recognition of these coexisting processes is not enough. We know that under changing conditions there will be realignments; new relationships of the parts to the whole and new patterns will be created. When a system as a whole—in this instance the social work profession—faces new external demands or a functional imbalance, systemic theory tells us that a new balance can be effected when the components again contribute some distinctive properties to the whole. Thus the whole enlarges its common base, and its parts (in this instance the methods) are freed so that there may be an exploration of the new ranges of their properties.

If we pursue this logic to its practical conclusions it becomes apparent that a merging of methods or a generalist approach in practice and in education will be insufficient. Some provision for retention of a specific identity which encourages and supports each method will be necessary.

In our conceptual scheme the professional worker's identification both with the common and with the distinctive is required. Specialization produces a reference or anchor point which needs sharpening when the field moves drastically toward commonality, just as commonality needs encouraging when the profession becomes preoccupied with specificity. Every worker must have two concomitant sets of skills in his professional armamentarium—one which is derived from the common base of the profession and establishes him as a social worker, and one which represents his special competence with a discrete unit of service. The state of discomfort and uneasiness produced by dual foci needs to be regarded as a natural phenomenon, not to be resolved but to be maintained as an essential balancing ingredient in a generic-specific system.

It is important to mention here an assumption that occasionally appears in our literature. This assumption, which we believe to be erroneous, is based on the notion that we must "break the fetters"

of a methodological tradition rooted in service to the individual, small group, and community as client systems. There is the suggestion that we have created these three systems to meet our idea of method. In our view it is not that the methods have created the client systems; it is rather that our clients naturally coalesce into certain configurations. So long as people function as individuals, in small groups, and in larger congeries, so long will our methodological structure need to heed this social reality.

It is not for us to obliterate the specificity of the methods but rather to draw from each the knowledge and practice concepts which belong in the common sphere as elementary equipment of all social work practitioners. It is necessary to clarify an assumption that this common sphere is more than a common orientation or "point of view." It is, in fact, method to be shared by every member of the profession.[3]

At the most modest level of expectation we would assume that the function of the common method is to enable every social worker to: (1) engage with any client system—individual, group, or community; (2) determine the predominant working unit that may be most productive in a given span of time, problem, and purpose; (3) determine the limits of his own expertise and the necessity of calling upon others with a more specialized competence.

Since we relate group work method to a common method, we shall explore several concepts traditional to group work that now seem relevant to the larger whole. Group work's historical concern for the development of the group as a whole, for the impact of the group on the individual, and for the relationship of the group to the larger community, serves as a framework in which we can distill concepts that are salient to the function of the common method.

Let us begin with group work's perspective of *the group as a dynamic system*. Since this knowledge concept is fundamental to

[3] Harry Specht and Frank Riessman, "Some Notes on a Model for an Integrated Social Work Approach to Social Problems" (New York: Mobilization for Youth, 1963; mimeographed), p. 10. The authors advance the position that "the generalist approach is a point of view rather than a method of work," but they agree that the generalist point of view does not preclude specialization in a method of work.

all work with groups and transcends all variables, we consider that it rightfully belongs in the common-method sphere. This concept holds that the human group has a life process of its own. At the core of this process is the internal dynamic of elaboration. Regardless of the purpose of the worker, the objectives of the agency, or the motivation of individuals, the group insists upon creating its own integrating response to these elements. This push toward collective elaboration is as compelling and inevitable for the life of the group as is breathing for the individual. It will be operating whether or not the social worker allows it into his awareness. Unless the social worker recognizes this force, he may inadvertently act as a constricting or controlling factor. He will be affecting process without benefit of disciplined purposefulness.

In recognizing collective elaboration, it is necessary for the social worker to understand that in this process there is always a residue of unfulfilled individual motivation just as some part of the product of elaboration is owned by each participating member. The loss along with the gain experienced by every member of any group, be it family group, peer group, counseling group, community group, will be taken into account directly or derivatively by the social worker.

One aspect of elaboration is the emergence of expressive ties in groups originally constituted as task-oriented. The surge toward participating together experiences in groups wherein priority was first assigned to verbalizing expressions of feeling is the converse of the same process.

Increased interaction between instrumental and expressive modes of functioning in the life of every group amplifies the range of service possibilities in relation to individual and social needs. With this knowledge of the group, the social worker may respond in a less restrictive fashion and with new courage to the evolving group process. Expanded vistas for helping may result. The counseling group may move into action; the community task group may offer nurturance to its members.

Another significant perspective on the group which seems to belong in the common method leads us to view the group as an instrument in support of societal values. This is the concept of the

democratically organized group. Historically, group workers have held to this concept as the ideological cornerstone of their method and have built skills around it. Basic to these skills is the knowledge that structure with concomitant distribution of authority will evolve in every group. The structural form which is developed by a given group is not solely derivative of the group's function but also has its societal roots. The larger society, through various institutions, including our own profession, encourages its members to expect and to perpetuate forms of group organization that embody its values. As most group workers know, cultural expectations which reflect democratic values need not be expressed through the formal administrative roles of president, vice president, and so on, but are seen in the norms which govern the assignment of authority, the degree of participation, and the code of fair play. Whatever may be the purpose for which a group convenes, it must be assumed that its structural development will take into account such cultural expectations, perhaps in compliance with them, perhaps in deliberate violation of them. This democratic model affects the American family group as it does the peer group.

There are professional workers who either challenge or ignore the relevance of this concept of democratic structure in therapeutic work with groups. Others neglect to bolster democratic means in the small group when community objectives seem to be of vital importance. We submit, in view of our knowledge, that concepts regarding the democratic group must be awarded a place in the common method. Group work's contribution to the common method lies in reinforcing and putting into operation within the small group the commitment of the profession to its democratic values.

A parallel position is found in the field of mental health. Jahoda makes the point that it is "required from those working in the mental health field . . . to make explicit the values which induce them to select certain criteria." [4] Wallerstein, reviewing the literature of psychotherapy, notes the value-laden content found in

[4] Marie Jahoda, *Current Concepts of Positive Mental Health* (New York: Basic Books, Inc., 1958), p. 80.

definitions aimed at determining the nature of mental health.[5] Democratic constructs pervade most models of idealized individual functioning.

We assume that the small group, adhering to democratic structure and values, is the core societal unit by which alienation may be prevented and individual social functioning implemented. As social workers, we may choose upon entering a group system to lend our weight to modes of group functioning that move toward realization of this idealized model of the healthy group or to support by default the possible emergence of other social arrangments.

If we accept the logic that the values of social work need not be dissociated from its practice, then the common method must make provision for a social worker's implementing democratic values in each and every group in which he functions. In particular, the common method must require examination of the authority which the professional worker carries in a group. Do we allow for the fact that authority should be shared? Do we allow for evaluation of our authority? Do we help our group to withstand our authority, permitting it to be put to the test? And lastly, in an educational sense, do we use our role as a model for responsible use of authority?

A third group concept which enlarges the common base is that of group contagion. This concept is pertinent at all times to work with groups and takes us further into understanding the individual as he is affected by group experience.

Contagion can serve as a motivational force by which a common purpose may be carried out. It can be a formidable foe of group discipline, containment, and achievement. Recognition of the dynamics in this powerful group process sheds light on integrating or disorganizing elements of individual functioning.

The crucial psychological condition involved in contagion is the abnegation of some measure of personal responsibility as the individual reacts to collective evaluations. Contagion can reduce the

[5] Robert S. Wallerstein, "The Problem of the Assessment of Change in Psychotherapy," *International Journal of Psychoanalysis,* XLIV (1963), 31–40, for a discussion of the value components in current concepts of positive mental health.

strictures of a rigid superego, carrying into new experiences some who dare not venture alone. It can fortify a faltering ego, pushing into constructive or destructive avenues some who dare not be alone.

Sensitized to this process, the social worker can relate to the individual's susceptibility to influence, whether selective or pervasive, his capacity for spontaneous action, his isolation or alienation from others, the strength or impairment of his self-image as a person who can be independent, and his threshold of panic in the face of uncertainty or threat.

Contagion, when taken further into account in professional assessment, can significantly influence or alter the choice of unit of service. For example, in one person-problem-situation configuration the contagion force in the group may be utilized. In another, protection or separation from it may be necessary in the interests of an individual or of the group.

Within the community system the worker may depend upon the potency of this process in relation to task achievement. Within the individual system, the worker may broaden his range of interventions when spontaneous or fortuitous behavior is recognized as reflecting a complex of intrapsychic and collective phenomena.

More broadly, contagion in the context of a common-method framework invites thoughtful consideration of social work's orientation to process and change. Social work methodologies have been built on the conservative assumption that change will be steady, persistent, and logical. Characteristically, contagion often effects change with rapidity and seeming unpredictability. Contagion creates a special kind of crisis for which we may need new technologies if we are to work with all client systems.

We turn now to two group work skills that we believe belong in the common pool: skill in relating with informality; and skill in dealing with collective hostility. Though these skills do not apply universally to the full range of client systems, they are absolutely essential to any effective engagement with clients in groups.

Focus on informality brings to mind the historic stereotype of the group worker who carries his professional role in the back pocket of his jeans. How stanchly group workers have defended

this image even as they have been somewhat professionally embarrassed by it! As voices in the profession call for a less pretentious and more informal meeting of the client on his own ground, we find that the special talent of being able to work in this fashion answers a universal need in the profession. It becomes necessary for group work to make more explicit the dimensions of this talent and to translate it into professional skill.

A stance of informality requires of the social worker a steadfast management of himself in order that the professional commitment to the client and his needs is ever maintained. Within this context skill in informality requires:

1. Open acknowledgment of the limitations of one's own expertise

The worker must be prepared to communicate his delight in the process of learning.

2. Engagement in play without surrender of one's sense of reality to the fantasy of the endeavor, whether it be play with rules, with materials, or with words

The worker must know that he is playing even as he knows that he is working.

3. Relinquishment of prescriptive role expectations

While risking noninstitutionalized behavior, the worker must make clear that he is counting on his own and others' creativity to evoke spontaneous and appropriate behavior.

4. Assertion of trust

The worker must convey his belief that his own ego will not be assaulted and that there will be no exploitation of the other person's vulnerability.

In the common sphere of social work there is already a body of knowledge, principles, and techniques to be used in dealing with individual hostility, but collective hostility has other facets which still need to be examined. Anyone confronted with a hostile group knows the ominous quality of collective anger, whether it be actual or potential. Individual hostility may become magnified in the group, and collective affect may further derive substance and direction from multiple sources in the group. Skill that is adequate to deal with individual hostility may be insufficient to cope

with the magnitude of the problem. What, then, constitutes the group worker's professional skill in regard to this aspect of social functioning?

Skill in dealing with group hostility requires:

1. Recognition of hostility as a natural, expected occurrence in the life of the group and anticipation of issues that will evoke an intense response

The group worker will achieve psychological mastery of his own reactions to his powerlessness by his preconceptions of what may occur. Thus his toleration level is strengthened, and he will offer a core of stability in the face of group panic.

2. A focus on hostility as the property of the group and a problem to be solved by it, not for it

The worker will ask the group members to recognize the commonality of the anger that is shared by all, even if it is expressed only by a few, or he will help the group to isolate the problem so that it can be managed.

3. Determination with the group of elements of displacement, ambivalence, and distortion so that appropriate action can be taken

The group worker will maintain perspective on both latent and manifest aspects of group feeling in order to help the group evaluate the relevance of its resolution. He will be prepared to be used as the object of displacement and on occasion will deliberately cast himself in this role either to protect the group's scapegoat or to provoke cohesion.

4. Assessment and maximization of the group's resilience for recovery from hostility

The group worker can count on several resources for group strength in working through its anger, such as individual differences in intensity of feeling, individual autonomy, personal and subgroup loyalty, reliance on leadership, and fear of loss of control.

5. Utilization both of his own and of external authority

The group worker is bound to keep the destructiveness of anger within responsible confines.

We have set ourselves the task of finding some reasonable posi-

tion by which we may proceed to study group work method in relation to the urgencies of new demands. Through formulating the coexistence of a common and specific sphere of method, we have found it possible to reaffirm the fact that we are social workers first and group workers secondarily. We have also found that this formulation, in affirming our contributions to the profession, makes possible continued and intensified development of our unique experiences and technical skills. The knowledge, concepts, and skills we have discussed are illustrative of the work that is to be done in relating a single method to the common base. In the process of determining what the group work method has to contribute lies the opportunity for sharpening and extending our conceptualizations to a broader spectrum of practice.

The Further Development of Group Work as a Separate Method

by EMANUEL TROPP

ANY DISCUSSION OF THE ISSUE of generalization *versus* specialization in professional social work practice must be placed in some philosophical perspective. There have always been historical swings and shifts in what is considered acceptable as a plausible view of the nature of knowledge. An example of one of the more recent trends was stated in 1961 by Hannah Arendt, as follows:

> There exists . . . a silent agreement in most discussions among political and social scientists that we can ignore distinctions and proceed on the assumption that everything can eventually be called anything else.[1]

Those presently concerned with knowledge in all fields have made some movement away from this nihilistic frame of mind, which has been endemic in this country for many years. The nihilistic approach—to eliminate differences, to obliterate entities, to emphasize the relative, to deny the possibility of really knowing, to deplore classification—this has been the intellectual tone that has dominated our recent past and from which thinkers in all fields are just beginning to liberate themselves.

The newest "wave of the future" in social work is the movement toward a unitary method of practice, and this wave has not yet reached its crest. The movement had its earliest antecedents in the first formulations of the generic principles that underly all of social work. With this early approach there can be no argument. For example, group work is definitely a branch of social work, but

[1] Hannah Arendt, *Between Past and Future* (New York: Viking Press, 1961), p. 95.

a branch implies not only connection but also separation, and the two are quite visibly consistent.

The next stage occurred shortly after professional unification and at a time when caseworkers were discovering how to use the group as a treatment technique. The most recent stage has appeared in the new style of community organization, which foretells not merely a double merger but a triple one, which will result in the all-purpose social worker. This merger has something of the quality of a heroic myth, and it is truly more related to dreams than to reality. For, if the condition of social work knowledge is still as primitive as assemblage of its leading spokesmen affirmed at the Princeton conference in 1964,[2] then talk of merger can only be interpreted in line with the theory of frustration. In the combination of weaknesses we are creating, not strength, but further dilution.

There is only one conceivable reason that the present issue of a unified social work method *vs.* specialization can still be considered discussable, and that is because it is legitimate for caseworkers to be able to deal with people in group settings; group workers should be able to deal with individuals; and community organizers, with both individuals and groups. But these are very limited objectives and a far cry from claiming either that there is only one social work method, or, if there are three, that it is possible to train a person to have equal professional competence in two or three methods.

Either of these claims is in utter contradiction with what we know of the development of professions and of scientific knowledge. In discussing the condition of the behavioral sciences today, Robert Merton notes:

> as the number of behavioral scientists increased and the diversity of their ideas was compounded, there has come about . . . a growing differentiation in their scientific work . . . the American learned society of psychologists now has twenty-two divisions. . .

[2] *Building Social Work Knowledge* (New York: National Association of Social Workers, 1964), especially pp. 11, 14, 72–73, 80–81, 92–93, 107–8. Also, for a more specific application of some of these concerns to the matter of social work method, see Helen Harris Perlman, "Social Work Method: a Review of the Past Decade," *Social Work*, X, No. 4 (1965), 166–78.

Yet, in the main, the danger that important classes of problems will be lost to view as a result of great specialization seems not to have materialized as often as might be supposed. . . . growing specialization has narrowed rather than widened the separation of the behavioral sciences. . . . [and] it is important to note that all this does not result from the cultish belief that it is good to "interdisciplinize". . . . In these collaborations. . . . They do not abdicate their competences but merge them. This becomes the easier to do as each . . . has successively found its distinctive place in the academic scheme of things. . . . the specialization of knowledge . . . goes hand in hand with the consolidation of knowledge.[3]

Now this was supposed to have been the original intention of the professional merger of the various social work disciplines, but somehow merger seems to have led the profession away from the idea that specialization goes hand in hand with consolidation. It is not very difficult to demonstrate that since unification the discipline of group work has produced far less knowledge-building and has instead willingly yielded to its loss of identity and to "inevitable" absorption.

This process can be traced from the change-over to "group service" by "group work" agencies, and the gradual introduction of the all-inclusive category of "social work with groups" as contrasted with "social group work." It has naturally led to the point where any social worker who does anything with groups is considered to be doing group work. The present level of the practice literature is a further indication of the stagnation that now exists. One writer not long ago reviewed the accumulated literature on group work in psychiatric hospitals and came to the conclusion that most of the articles seemed to be repetitions of the same "fairy tale," beginning with serious problems and ending with fine results, and always sounding as though they were reporting an independent new discovery.[4]

The implications of the present level of social work knowledge and of the known elements in knowledge-building in any science

[3] Robert K. Merton, "The Mosaic of the Behavioral Sciences," in Bernard Berelson, ed., *The Behavioral Sciences Today* (New York: Harper & Row, 1964), pp. 251–54.

[4] Barbara W. Rostov, "Group Work in the Psychiatric Hospital: a Critical Review of the Literature," *Social Work*, X, No. 1 (1965), 25.

must lead to the conclusion that the path of merged method is an illusion and that following it will further postpone the necessary work to be done. In fact, about the only plausible explanation for even considering the merged method is that there is not enough knowledge presently organized to make the task appear unrealistic—*and such an admission should be cause for enormous concern.* To clarify by contrast, one needs merely to weigh the prospect of a similarly merged method for cardiology, orthopedics, and gynecology. The very thought says worlds about profession, science, and method.

What is the phenomenon called "the group"? The term is currently employed as though it meant the same thing to all users of the term. It appears to be generally believed that one can learn about "group process," "group interaction," and "group relationships," thereby achieving a comprehension of "group concepts" and finally understanding "the group."

Of course, there is no such thing as "the group." [5] There are a number of basic group classifications, and each has its own peculiar purpose, structure, and function. The group processes that flow from these different functions are hardly the same at all. To have learned "group concepts" means to have learned generalizations so broad as to have little utility; or better, to have learned concepts relevant to the specific type of group one serves; or worse, to have learned concepts inappropriate to that group.

Those groups which are organized to pursue common goals by common decision and common action require the essential skill of group work, which involves a high degree of structural and operational knowledge. Groups that are not organized for the pursuit of common goals or, if so organized, do not pursue them by common decision and action—as a necessary criterion upon which their function depends—do not require the essential skill of the group worker, although they may benefit from this skill as well as from others.

In the recent literature it has been assumed that a task group is

[5] This discussion is adapted from portions of Emanuel Tropp, "Group Intent and Group Structure: Essential Criteria for Group Work Practice," *Journal of Jewish Communal Service,* XLI (1965), 229–50.

one in which the task is the primary consideration, while in a growth group the social growth of the members is paramount. However, when groups are divided in accordance with common-goal criteria, the goal-task contradiction disappears. It is no longer a matter of asking whether the task takes primacy over the growth since it is the very achievement of the task in a common-goal group that provides the key dynamic around which social growth takes place.

It has also come to be taken for granted that whatever the purpose, content, and structure of an experience, if a group worker was leading it, it somehow became group work. What can be stated with greater assurance is that the group worker as social worker can help individuals to enhance their social functioning under many different circumstances; yet this does not mean that he is therefore doing group work.

It is possible to accomplish the broad purposes of social work in a group setting without doing group work. Those groups without a common-goal mechanism represent the peripheral areas in which other social workers can accomplish social work goals. These peripheral areas may truly be the "general practice" zones of social work, in which either caseworker or group worker may function. Yet, this extension of both into less concentrated areas of operation constitutes a subprofessional level of practice that has validity only when seen as an auxiliary service.

In professional casework there is a primary focus on the individual, an intensive examination of the personal and environmental factors in the particular case, a thorough diagnostic analysis of the individual problem, an individual treatment plan, and a complex method and skill of treatment, involving a sustained and concentrated relationship between worker and client. In professional group work, there is a primary focus on the group, an intensive examination of the aims and structural characteristics of the group, a thorough diagnosis of the group needs and of the process and content necessary to meet these needs, a plan for group movement, and a complex method and skill of group guidance.

In the zones of overlap, each discipline works toward both much more limited and much more general objectives than those which

it ordinarily aims to accomplish. Thus, "helping individuals in a group setting" is a generalized, nonspecific practice of social work that has the characteristics of neither intensive individual diagnosis and treatment nor of intensive group guidance.

In a treatment setting that focuses on group-goal achieving the social worker practices essential group work; but to assume, as we have said, that anything a group worker does with a group is group work is to reduce professional practice to meaninglessness. When the group worker functions therapeutically with a play group, he is carrying on a form of recreational therapy with very general social work objectives.

In determining the appropriate focus for the use of the group work process, the criteria must be found in the function of the group itself. If group engagement for group-goal achievement is the primary dynamic in the social growth of the members, then the combination of effective achievement and responsible engagement becomes the proper primary focus for the group worker. The planned construction and guidance of the optimum group structure and process to maximize the social growth of the members are the central areas of operation for the group worker. The individuals in his groups grow mainly through these efforts.

To carry out this purpose effectively, the professional should have mastery of group structural composition, group goal selection, and operational process guidance. Such mastery would entail understanding and skill in using a complex network of roles and communication patterns in the common-goal group; an extensive familiarity with varieties of content suitable for group goals and with criteria of quality for such content; and a high degree of skill in maintaining a fine balance between accomplishment and consent.

For group work, therefore, the areas of knowledge, both theoretical and practical, that must be studied, conceptualized, and integrated if one is to reach the stage of professional mastery are so great that the agenda for the growth of this discipline are immediate, imperative, and necessarily separate.

One of the very first hard realities encountered is the recognition that social work has contented itself too long with the elemen-

tary definition of a group as "two or more people in interaction with each other." For this rudimentary description simply speaks of social relationships; by the time this reality has steered a course through political science, sociology, organization theory, and finally through group work, it will be discovered that, when one moves from social relationships to organized groups, one is entering into a new and vastly more complex world. A great deal of the current problem has been due to the failure to recognize this vital difference.

Once having ventured into this world, one discovers that the profusion of existing concepts and formulations cries out for a special reordering and integration with the practice knowledge of group work into a coherent structure. Group work will first have to describe its own phenomena explicitly. Then it can proceed to develop classifications, distinctions, and connections of its own, while using related knowledge from other fields.

The combined theoretical and practice knowledge that awaits organization into a meaningful system for professional mastery in social group work may be roughly divided into five general areas: (1) a group classification system; (2) related structural systems; (3) related operational systems; (4) an analytical scheme of social maturity; (5) a prescriptive system of professional interventions. Within and beyond these areas are other more complex and more advanced segments, but these five provide a basis for present study. (In two previous papers, this writer has attempted some formulations in several of these categories.) [6]

In the area of group classification there are a number of basic group types, and the structure of each flows from the function. Careful study of each type is needed, to become sufficiently informed of the structural and operational necessities each creates, so that professional practice will be related both to an awareness of the distinctions and to an understanding of the respective functional needs. This first segment of uncharted knowledge cannot be easily located by reference to a standard text in sociology. There are important insights to be gleaned from a variety of sources, but

[6] *Ibid.*, and Emanuel Tropp, "Maturity in Social Functioning: the Developmental Goal of Group Work," *Journal of Communal Service*, December, 1966.

group work will have to do its own job of reformulation, the end product of much inquiry, analysis, and construction.

Having established a world of organized groups, the next necessary step will be to discover the implied structural systems; for the operational process cannot be comprehended without the structural base. In other words, study of the anatomy of groups must precede knowledge of their physiology. The key to structural analysis lies in the nature of the power through which the group achieves its purposes. The base of power is authority, of which there are various kinds. Authority is expressed through laws, rules, agreements, commands, sanctions, force. The differences between the structures of imposed authority and shared authority are many and intricate. For group work especially, the nature of shared authority is particularly important, including the dual roles of each participant as member and agent (reflecting the dualism of each person's private and public interests), the forms of common obligation (including consent, delegation, reservation, and controls), the uses and abuses of delegated power, and the problem of achievement versus consent.

From structure, one can then elaborate the operational systems by which the structures function. These involve: the means of setting goals; the processes of common deliberation, decision, and action; the criteria for effectiveness of the group, of its members, and of indigenous leaders.

After developing these systematic principles of classification, structure, and operation, group work will have to concern itself with the most appropriate function it can perform with individuals. It is posed here that this role will be found in the enhancement of social functioning toward an optimum of social maturity, and more specifically toward societal maturity, with the former seen as of the one-to-one variety and the latter as one within a functioning collectivity.

To create a construct of social maturity, it will be necessary to locate the dimensions of the social act, a process of factor analysis that will describe the basic social units (self, others, and society, with society defined as "self-plus-others as a unit"); the basic social relations (self-to-self, self-to-others, and self-to-society); and the

basic components of the social act (ideas, feelings, and actions). Matching this analysis there must be a second one, in regard to the nature of the volitional self, through which the individual utilizes the basic elements of cognition, valuation, and action.

By joining these two systems together, there can be created a schematization of social functioning and of social maturity. At the most advanced end of this schema will be found a system of societal maturity, which places far more complex demands upon the individual than does the lower level of self-to-other performance. Group work, while needing a fundamental grasp of the self-to-self and self-to-other systems, will have to devote its primary attention to its ultimate goal, which is maturity in the self-to-society system.

Finally, a methodology of intervention needs to be developed, based upon: an analysis of the effects of various types of societal relations on the steps in growth to maturity; the basic choices of action open to individuals in collectivities; the effects of group structure and operation on the choices available; the ways in which these choices indicate and affect maturity levels; and the ways in which the worker's selection of alternative interventions affects individual and group movement toward maturity.

With these tasks of knowledge-building still to be undertaken, the challenge of shaping a theoretical and applied science of group work becomes formidable enough to warrant the conclusion that it is only on a very low plateau that a merged method can hope to operate.

It should be noted that, historically, group work is at a quite early stage of development. The American Association of Group Workers was organized in 1946, to be dissolved a short ten years later in the merger of the professional associations. Group work has devoted the last decade to strengthening its social work base and connections. During this period, however, the connective elements have been stressed to the neglect of those that are necessarily separate, and the theoretical and methodological challenges in those crucially separate areas are still to be coped with.

The merging of methods is another move in the same direction of delay and retardation, and at a time when there is an increasingly urgent need for the discipline of group work to make the

next climb toward growth and maturation. If this trend continues, it may be said that the requirement of the entire social work profession for organizational unification will thus have been finally translated into the kind of ideological unification which obliterates the identities of separate theory and practice structures.

Group work remains a distinctive and vital method that is part of the social work enterprise, but it needs both the climate and the initiative to build that distinctiveness which can then meet with the other social work disciplines on common ground to carry out those tasks in which they have a mutual interest.

Employing the Aged as Foster Grandparents in a Medical Setting

by MILBREW DAVIS

THE FOSTER GRANDPARENT PROGRAM is a research-demonstration project sponsored jointly by the Administration on Aging and the Office of Economic Opportunity. It is based on the belief that institutionalized children need a warm, emotional experience with adults and that older men and women can provide this experience.

In nineteen states twenty-two foster grandparent projects are being conducted in hospitals, receiving homes, day centers, and in institutions for the mentally retarded, for dependent and neglected children, and for delinquent and emotionally disturbed children.

Bexar County, Texas, is an urban community with a population of 687,151. Of this number 49 percent are of Latin-American background, 7 percent are Negro, and the remaining 44 percent are Anglo. It is a community with large pockets of poverty; over 50 percent of the families have incomes of less than $3,000 per annum. Associated with this high incidence of poverty are the concomitants of inadequate housing, poor health, illiteracy, illegitimacy, and school dropouts. These conditions contribute in large measure to the high incidence of illness among children and infants.

The Bexar County Hospital District, a tax-supported institution that includes a 330-bed general, acute treatment hospital and a 250-bed geriatric and convalescent sanatorium, is an integral part of the South Texas Medical School of the University of Texas.

Since the District cares for the medically indigent of the county, the pediatric and nursery wards accommodate from ninety to a hundred children a day. The hospital also provides paramedical services for these children, some of whom must remain in the hospital for three or four months. Although their physical needs are met, however, these youngsters are deprived of the social interaction needed to achieve an emotional climate designed to foster mental health and normal development.

The philosophy underlying the hospital's decision to engage in the Foster Grandparent Program is twofold. In the first place, we believe that for a child to be mentally healthy and to develop normally, he must live in an adequately tolerant emotional climate which offers suitable resources for encouraging the adaptive functioning appropriate to his age. Secondly, we believe that men and women over sixty years of age have the capacity to provide a warm emotional experience for our hospitalized children; that they are capable of learning new techniques; that they can develop in themselves the feeling of worthwhileness that they have been denied by virtue of being on the economic scrap heap; and that their self-image and self-worth are sure to improve when they can supplement their inadequate retirement income and at the same time continue to be useful citizens of the community.

There are 1,032 foster grandparents authorized for the twenty-two projects, thirty-eight of whom are employed by the Bexar County hospital.

After the announcement in August, 1965, by President Johnson that this program for the elderly would be started at our hospital 294 elderly citizens sought to participate in the project. The largest number of applicants who met the minimum age and economic requirements were Anglo widows, and the second largest number were Negro widows. Although 49 percent of our population are Latin American, the small number of applications from that group may be attributed to the fact that literacy is a criterion for eligibility. Many elderly Latin Americans can neither read, write, nor speak English. Applicants ranged in age from sixty to eighty-one years. Their major sources of income were social security and old age assistance.

Our applicants gave as their primary reason for wishing to join the program the need to supplement inadequate incomes. They also cited boredom from inactivity, and a desire to be useful and to help others. We have observed that the elderly people who seem to function best as foster grandparents are those who are economically deprived and those who have lived rather active lives prior to retirement.

Many of our foster grandparents had been under medical care for hypertension, nervous tension, gastrointestinal disorders, and so on. Since retirement they were spending a great deal of time alone, preoccupied with worries about financial stresses, inability to find employment, family problems, and their own physical ills. Since they have been working with the children, they tell us, they eat and sleep better, they need to see a doctor less frequently and take less medicine, and their physicians have commented that becoming involved in the program was the best thing that could have happened to them.

These experiences are not unique to San Antonio. About a year and a half ago, Mrs. X., a Fort Wayne, Indiana, woman in her middle seventies, lost her husband and her son within the period of a few months. Bereaved and left with inadequate means, she was driven into despondency, despair, and discouragement. A professional counselor assigned to her case telephoned the agency director not long after the woman had been selected as a foster grandparent and asked: "What have you done to Mrs. X.?" He had seen her on the street and hardly recognized her, for she evidenced such vitality, vigor, and joyousness that she did not seem to be the same person.

Employment of these elderly citizens has not only affected the lives of these elderly persons themselves but also their relationship with their associates. They have commented on how happy their family and friends are for them since they are working again. This has definitely improved the foster grandparents' self-image and self-esteem. We have had telephone calls from foster grandparents' friends, ministers, and physicians who remarked how much this program meant to the elderly. In North Carolina a woman told the project director that employing her mother as a foster grandparent had "given her back her life."

The basic criteria for selecting candidates for the project were: a minimum age of sixty years; a personal income of $1,800 or less or a maximum family income of $3,000; ability to read and write simple directions and, if possible, to speak Spanish; some knowledge of, or experience in, working with children; ability to meet the minimum health standards required by the hospital; neatness and cleanliness in appearance; a demonstrated ability to follow simple instructions and to communicate with, and relate to, the staff, the patient, and relatives of the patient; and warmth, concern for, and interest in, children and a desire to work with them.

Upon acceptance as candidates, forty-two prospective foster grandparents were given two weeks of classroom instruction in child development and care, including practical experience on the wards with infants and young children. From these forty-two our quota of thirty-eight was selected, including five Anglo men and six women, one Latin-American man and twelve women, and two Negro men and twelve women. The remaining six were placed on the waiting list to be brought in as attrition depleted the original group.

When our foster grandparents began to work on the wards there was a great deal of apprehension on the part of the medical and nursing staffs, and they were accepted with many reservations. The foster grandparents were very cooperative, and in a short time it was recognized that they were providing a badly needed, invaluable service. The infants and young children seemed happier; they were quieter, adjusted to the alien environment faster, and were much easier to manage. Subsequently, the medical-nursing staffs began to look forward to the arrival of the foster grandparents and requested that specific children have a foster grandparent assigned to them. For example, a three-year-old boy whose epileptic-like seizures occurred about once per minute required constant attention. The attending physician requested that a foster grandparent be assigned to him both morning and afternoon. When a "grandparent" assumed some of the little boy's care the seizures were reduced by about half. The professional staffs were very grateful, for without the foster grandparent's attention this child would have been a management problem. Other cases in which these "grandparents" were helpful included burned children, those whose ill-

nesses required immobilization and/or isolation, children whose relatives did not visit often, and youngsters with feeding problems.

The children's response to the tender, loving care has been remarkable. They were usually shy and withdrawn when the foster grandparent first appeared, but on the second day they were more responsive and accepting, to the extent of competing for attention.

Other agencies are observing similar experiences. In Denver a battered child with severe burns and a skull fracture was obviously in severe emotional shock and was reaching out to everyone for affection. This emotional response was diffused and further complicated by the tender responses of so many adults at the hospital that the child was loving everyone and no one at the same time. The attending physician prescribed the assignment of two foster grandparents—one in the morning and one in the afternoon—to force the child to begin focusing attention on specific relationships. At the end of the month, the child's emotional and physical responses were amazing, and the physician acknowledged the role of the foster grandparents in achieving the desired objective.

In another instance, a child who had not spoken in five years is now speaking to his foster grandparents, and it is presumed that he will begin to talk to other people as time passes. A boy of twelve who had never spoken in his life can now say five words after only three weeks with a foster grandparent. In Fort Wayne, a five-year-old girl who had spent most of her time in children's institutions had developed a pattern of self-isolation, refusing to mix with other children or to enter into their activities in any way, and cried almost constantly. Within the short span of two weeks with a "grandparent" she began to smile, play, and listen attentively to stories read to her.

The response of the children has such a great appeal to our foster grandparents that they frequently arrive before the appointed time and want to remain after the scheduled hour. Furthermore, they have called in on their days off to inquire about the children assigned to them and have wanted to follow them in their homes after their dismissal from the hospital.

In our hospital the foster grandparents hold the infants, bottle

feed them, and change their diapers. They assist the older children with their meals if necessary, read to them, help them color books, and play with them. We have also found the foster grandparents most helpful in teaching the children to use eating utensils rather than their fingers, and to drink liquids from a cup or glass rather than from a bottle.

It was thought in the beginning that since 89 percent of our patients are Spanish-speaking, language might be a barrier for the children. However, during the first five months of operation we found this not to be the case. Assignments are made on the basis of the needs of the children and the capacity of the foster grandparent to meet these needs.

Initially, the presence of a foster grandparent was a threat to the parents of the children. The parents verbalized fear that the foster grandparents would take their children from them, that all the special attention, such as holding and feeding, would make it difficult for them to manage the children when they returned home. The foster grandparents were able to handle these situations quite well. The parents became so impressed and so appreciative of this extra care that they began to question our staff regarding child care and the illness of their child.

In view of the concern on the part of the parents, and with the approval of the consulting pediatrician, we set up classes for parents of children who were currently hospitalized or who had been recently hospitalized. These are conducted by a pediatrician, chosen by the consultant, and the registered nurse with the project. In these semimonthly sessions child development and care, proper diet and feeding, and causes of diarrhea and malnutrition, with emphasis on prevention, are discussed. Recently, these sessions were extended to include women in the hospital pending confinement and those who had already delivered. The response to this preventive medicine approach has been gratifying. We have had consulting with us and participating in the discussion groups, dietitians from the hospital, nurses from the school of nursing, and hospital staff and nurses from the local Visiting Nurses Association.

While it is yet too early to determine all the positive results of

the project, it is believed that through the preventive medicine technique of discussion sessions with parents, follow-up home visitation by our foster grandparent professional staff to assist the parents in the home, and the cooperative efforts of the community agencies in this program, the number of hospitalizations due to malnutrition and diarrhea, which are major problems of our infants and young children, will be reduced. When hospitalization is required, the length of stay will be minimized as a result of the additional ingredient of tender, loving care which helps the infants and young children to respond more readily to medical care.

The program has had some economic impact. In our own hospital the foster grandparents are working so well that at the request of the Department of Nursing two of them have been taken on as nurses' aides, and others are being considered for employment as vacancies occur. The office of Administration on Aging has indicated that as a result of this program foster grandparents in other projects have been able to obtain other employment, project directors have been able to find jobs for those they could not hire, and several foster grandparents, because of their earnings, will qualify for social security coverage.

We would be amiss if we did not recognize a further preventive value of this program. The Administration on Aging records indicate that many applicants have been helped with their social problems by referral to appropriate agencies for assistance. Medical problems were detected, and referrals were made for follow-up medical care.

The program has demonstrated that our elderly citizens are wanted and needed. It benefits both the old and the young—the old by providing remunerated employment, development of skills and job creation, purposefulness in the later years of life, and human dignity; and the young by providing opportunity for emotional satisfaction, the learning of social skills and self-confidence. Both immediate and long-term benefits for the individual and the community are apparent.

First Steps in a Nationwide Study of Child Abuse

by DAVID G. GIL

PHYSICAL ABUSE OF CHILDREN by their parents has attracted much interest in recent years. This renewed concern with an ancient phenomenon on the part of physicians, social workers, judges, and lawyers, as well as the mass media of communication and the lay public, is reflected in widespread enactment of new legislation aimed at dealing with incidents of abuse. It has also stimulated various research efforts, including a nationwide study [1] by Brandeis University designed to examine selected theoretical and practical issues relevant to social policy and professional practice.

Professional practice tends to increase in effectiveness as its knowledge base broadens. One avenue to broadening the knowledge base concerning social phenomena is the epidemiologic approach, the potential value of which for problem-solving was stressed at the 1962 National Conference on Social Welfare by Eleanor Cockerill.[2] In discussing the principles of epidemiology, Miss Cockerill deplored the fact that the field of social welfare has availed itself of this powerful resource to a limited extent only. The research on physical child abuse discussed here employs a na-

[1] The Child Abuse Research Program is supported by research grant H-83 from the Children's Bureau, Welfare Administration, U.S. Department of Health, Education, and Welfare. This support and the consultation of Children's Bureau Staff are gratefully acknowledged. The author also wishes to acknowledge the assistance of Dr. John H. Noble, Jr., Associate Director of the Study.

[2] Eleanor E. Cockerill, "The Epidemiological Approach to Problem-Solving," in *Social Work Practice, 1962* (New York: Columbia University Press, 1962), pp. 41–48.

tionwide epidemiologic approach to one complex social problem. In our search for substantive knowledge concerning this destructive phenomenon, we also expect to contribute methodological knowledge toward future applications of epidemiologic strategies to social welfare issues.

The central focus of this research is on a limited range within the broad spectrum of abusive treatment of children. This range is defined by the presence of physcial components in the abusive interaction between a caretaker and the child in his care. Accordingly, we define child abuse conceptually as "physical attack and nonaccidental physical injury, including fatal injury inflicted upon children by persons caring for them."

This definition, though sound conceptually, is not quite satisfactory for describing real life situations because the term "nonaccidental" is ambiguous, and the boundary between the phenomena of neglect and abuse is vague.

The phrase "physical attack" has been included since physically abusive behavior does not always result in clearly observable physical injury. Physical attack is distinguished from "sexual attack," which has been excluded from the definition because perpetrators of sexual abuse are assumed to have motivations different from those of perpetrators of physical abuse. The term "nonaccidental" refers to the presence of deliberate elements in the behavior of persons involved in physically attacking or injuring a child. The presence of deliberate elements does not, however, imply absence of chance elements. Some incidents of inflicted physical injury may include elements of chance, and at times it may be impossible to determine the role played in a given incident by chance and that played by deliberate behavior. Further complication lies in the fact that "accidental" behavior may include "unconsciously deliberate" elements.

Thus, while the boundary between "pure" accidents and physical abuse can be drawn fairly clearly on a conceptual level, it will often be difficult to differentiate between these two types of phenomena without a thorough examination of the motivations which underlie the manifest behavior involved in given incidents.

The phrase "physical injury . . . inflicted" refers to conditions of impairment and abnormality of physical structure or functioning attributable to deliberate elements in the behavior of persons caring for the children. Deliberate elements of behavior in this context include not only acts of commission but also acts of deliberate omission, such as starvation that does not result from neglect or ignorance. Once again we are faced with an unclear boundary since acts of omission resulting from neglect or ignorance are likely to produce physical manifestations similar to those that result from acts of deliberate omission.

The phrase "persons caring for them" refers to a person or persons functioning in a *de facto* child-caring role for the child whom they physically attacked or upon whom they inflicted injury. The child-caring role is not defined quantitatively by duration in time but qualitatively by the nature of the constellation existing between the child and the person. This constellation involves the element of actual or presumed responsibility for maintaining or guarding the child's well-being and welfare.

The phenomenon of physical child abuse has been explained by many investigators as attributable to the individual psychopathology of the perpetrator. Such an explanation seems to disregard other possible contributing factors, such as environmental stress. The hypothesis underlying our investigation is that child abuse is a product of interaction within family or household groups. Since this interaction is shaped by social forces within and outside the group as well as by the psychodynamics of the group and its individual members, child abuse may be causally related to varying combinations of forces which emanate in part from the social environment and in part from pathological group processes and individual psychopathology. Incidents of child abuse may be thought of as being distributed along a continuum, one end of which represents psychopathology and the other, environmental stress. Certain incidents may be situated at either extreme; most incidents, however, can be expected to lie at some intermediate point.

Investigation of the foregoing hypothesis may have important implications for the planning of prevention and treatment pro-

grams relative to physical child abuse, since different causal contexts suggest different intervention strategies. If environmental stress proves to be an important contributing factor of child abuse, then social and environmental measures are likely to affect the incidence rate of the phenomenon. If, on the other hand, environmental stress will be found to be a minor factor, and most incidents are attributable only to psychopathology of the perpetrator, then social and environmental measures will be of limited direct value.

Our conceptualization of child abuse does not envision an absolute, qualitative difference between adults who physically abuse children and those who do not. Rather the difference is considered quantitative—one of degree. Many adults who never abuse their children may nevertheless harbor abusive fantasies and impulses toward them at one time or another. In some adults these fantasies and impulses may become overtly manifest, while in others they may take a covert form. For example, some adults may subject their children to accident-prone situations, or may neglect them in various ways. The important question suggested by these considerations is: What psychological and environmental factors lead to different behavioral outcomes in spite of possibly similar negative attitudes and impulses toward children in one's care?

As a final point one should mention that some children may be more provocative than others in their behavior and that such children may play a contributing role in their own physical abuse. Such behavior may derive from constitutional or congenital factors, from environmental experiences, or from both. Irrespective of origin, such possible behavioral patterns on the part of children must not be overlooked if the dynamics of the phenomenon are to be fully comprehended.

The following issues and their possible interrelationships have been selected as major foci for the research on child abuse:

1. *The incidence rates of child abuse in the total United States population and in specified subsegments of this population*

To obtain a count of incidents of child abuse and thus an incidence rate for the total population and for selected subgroups is a complex task. This complexity is due to the essentially private na-

ture and low visibility of the phenomenon, to variations in legal definitions of who is a child and what is child abuse, and to variations in legal requirements concerning the types of situations which are reportable, the sources and recipients of reports, and the responsibilities of recipients of such reports.[3] Furthermore, there are variations in compliance with reporting legislation between states and between political subdivisions within any one state.

Because of all these circumstances it is possible to obtain only approximations of incidence rates. We intend to approach the investigation of incidence rates in stages, starting with a study of the most visible cases, those reported through the legal network. We shall then proceed toward the less visible parts of the phenomenon in several specially designed studies.

The purpose of examining incidence rates for subsegments of the population is to identify groups that have a significantly higher incidence rate than is found in the population as a whole. At present we do not know for certain whether there are such groups, although a recent study in New York City [4] and previous studies in other communities suggest this possibility. If it is possible to identify groups with higher incidence rates, such findings could have implications for the selection of target groups in planning preventive intervention measures.

Subgroups can be defined and selected by various criteria. We are tentatively thinking of using criteria of geographic region, ecologic distribution, socioeconomic class, ethnicity, race, religion, sex, age, family structure, and family size, as well as various combinations derived from these criteria.

2. *Characteristics of family or household units in which incidents of child abuse occur and characteristics of individual members of these units*

We expect to obtain insights into the dynamic aspects of physical child abuse by examining configurations of characteristics of individuals and family units involved in child abuse. We intend

[3] Vincent DeFrancis, *Child Abuse Legislation* (Denver: American Humane Association, Children's Division, 1966); Monrad G. Paulsen, "Legal Protections against Child Abuse," *Children,* XIII (1966), 43–48.

[4] Betty Simons *et. al., Child Abuse, a Perspective on Legislation in Five Middle-Atlantic States, and a Survey of Reported Cases in New York City* (New York: Columbia University School of Public Health and Administrative Medicine, 1966).

to examine demographic, socioeconomic, psychological, and health characteristics. Different methods will be utilized in a series of studies in order to obtain these various types of data.

Because we consider a family or household as an interacting system, we are interested in the characteristics of all members of reported units and not just of those members who were actively and overtly involved in the abuse of a child. Implied in this approach is the assumption that individuals who have not been involved overtly in such incidents may, nevertheless, have played a covert part in them. Furthermore, we are interested in the possible part played by children themselves in precipitating abuse. It seems, therefore, necessary to compare the characteristics of other children in the same family or household.

3. *Circumstances surrounding incidents of physical child abuse and the nature and extent of injury sustained by the victims*

In studying detailed circumstances surrounding incidents of child abuse and the nature and extent of the physical injuries one of our main interests is to identify possible "typical" recurrent patterns. If we succeed in identifying typical constellations of circumstances, such findings will provide clues for preventive programs.

Circumstances surrounding incidents of child abuse involve the sequence of events leading up to and following the act rather than only the act itself. In this connection one must keep in mind that actions of caretakers after injuring a child are highly important in terms of protecting his health and welfare since the condition of many injured children is aggravated as a result of delayed medical attention or lack of medical care.

4. *Patterns of social welfare, health, and legal intervention measures utilized in dealing with incidents of child abuse and their effects and effectiveness*

The study of patterns of social welfare, health, and legal intervention measures which deal with incidents of child abuse is related to the preventive component of this program. We are interested in studying:

a) Channels of communication through which information con-

cerning incidents of child abuse flow and possible blocks in these channels

b) Services existing in given communities which constitute a potential resource for dealing with child abuse

c) Intervention measures actually taken by different functional service systems and the extent of coordination among them in relation to specific incidents of child abuse

d) Lacunae in service patterns in communities as reflected in the foregoing items

e) The effects and effectiveness of existing and especially developed intervention measures in terms of the health and welfare of the abused child, his family, or his household unit, and the community of which they are a part.

The epidemiologic survey which constitutes the first major phase of the child abuse research program is designed to analyze all incidents of child abuse which will be reported in 1967 through the legal channels of nearly all states of the United States. Reported incidents are, of course, only an unknown and possibly a biased fraction of the total phenomenon.

By the end of May, 1966, all states except Hawaii had enacted child abuse reporting legislation. Reporting is mandatory in forty-three states and discretional in Alaska, Missouri, New Mexico, North Carolina, Texas, and Washington.

In establishing the framework for the recruitment of our study population we were guided by the following considerations:

a) Every state ready to participate was to be included, since little is known concerning possible interstate variations of incidence rates, effectiveness of reporting procedures, types of child abuse, and factors likely to underlie such variations.

b) An entire year, 1967, was selected in order to identify the effects of possible seasonal variations.

c) A large cohort was to be recruited in order to increase the probability of statistically adequate representation of low-frequency types of physical child abuse. Current reporting rates suggest that more than six thousand incidents are likely to be reported for the United States population during 1967.

d) Notwithstanding our conceptual definition of child abuse,

every incident reported during 1967 under child abuse reporting legislation of states participating in the study will enter the study cohort. This simple and unambiguous operational definition of the cohort intake will eliminate errors due to misinterpretations of the conceptual definition on the part of field personnel. Provisions will be made for screening intake by research staff in terms of the conceptual definition of child abuse, and for adequate classification and control of the broad range of phenomena which will enter the study cohort. Because of the broad intake criteria a special issue for data analysis in this context is the differentiation between cases in which abuse has been established by a court, cases in which abuse has been established by other than court procedures, cases in which abuse is merely suspected but available evidence is inconclusive, and cases in which abuse was suspected but evidence suggests that the original report was erroneous.

Cases will be recruited with the aid of central registries which will be set up during 1966 in every state participating in the study. Local officials designated by law as recipients of reports of child abuse will be asked to forward copies of each report to the central registry of their state as soon as possible after an incident is brought to their attention. Procedures for reporting cases to the central registries from the local level will be designed in accordance with the legal and administrative patterns of each state.

The central registries will forward to the study office copies of each report on child abuse received by them during the study year. During the developmental year of this program many states set up central registries and others began to develop procedures for putting registries into operation. A guide for a child abuse report form was developed and made available to the states. The suggested form was designed to provide information on the identity, sex, age, and race of the abused child, his parents or guardians, and the person suspected as perpetrator. It also seeks information on the injury sustained by the child, on the circumstances surrounding the incident, and on known previous incidents of abuse involving the same child, family, or perpetrator. Finally, the form asks for information on the immediate legal, medical, and social

welfare dispositions of the case, and on the reporting source. The items suggested for inclusion on the report form are roughly equivalent to those required by child abuse reporting laws of most states. It was suggested that the states print their state law on child abuse reporting on the reverse side of the form.

This form, or one similar to it, will be used by local recipients of child abuse reports for reporting incidents to central registries, and copies will be used by central registries for reporting to the study office. The same form can also be used by physicians, hospitals, and others in reporting child abuse to the local authority.

Central registries are expected to serve a useful function beyond their role in the child abuse research program. Such registries can assist health, welfare, and law-enforcement authorities within and between states in attempts to identify and diagnose suspected recidivists. Past studies of child abuse have noted tendencies toward geographic mobility and recidivism among individuals and families involved in child abuse. Central registries may, therefore, develop into important tools within the protective service system of the states.

Data collection for the epidemiologic survey will be carried out on two levels:

a) A limited set of data will be collected on each incident of child abuse reported during 1967 to the central registries. These data will be derived from the registry report forms and will be supplemented by a terminal report to be sent to registries from the local level. The terminal report will indicate the final disposition of each registered incident.

b) A comprehensive set of data will be collected on each incident of child abuse reported during 1967 in a sample of approximately forty-five cities and counties which were selected at random from nationwide strata based on the ecologic and regional distribution of the United States population. The selection procedures were designed to insure a statistically representative sample of all cities and counties in the United States. Since little is known now concerning the phenomenon of child abuse, its distribution in the population, and reporting patterns, variables relating to child

abuse did not serve as criteria for strata from which the sample of communities was drawn.

About two thousand incidents of child abuse are expected to be reported during 1967 in the cities and counties of the sample. Comprehensive data on these incidents will be collected by means of a standardized, largely precoded research schedule. Schedules will be completed by staff members of local welfare departments, juvenile courts, and other agencies having direct service contacts with the families and individuals involved. Field personnel will be familiarized with the research schedule prior to the study year, and their observations of cases and data collection are expected to be guided by the schedule.

Schedules will be completed either contemporaneously with service to the families involved or at the time service is terminated. They will be checked for completeness at the terminal point of contact. Schedules on cases still active on June 30, 1968, the cut-off date for data collection, will be filled out on or about that date.

In accordance with the foci of the study the research schedule has been designed and pretested to collect the following information: demographic and socioeconomic characteristics of individuals, families, or household involved in the incident; circumstances surrounding the incident of abuse, including data on the nature and extent of the physical injury sustained by the victim; health, social welfare, and legal measures taken in dealing with the incident.

The schedule for the epidemiologic survey is not intended to gather information on psychological factors. We plan to investigate the psychological dynamics underlying the phenomenon of child abuse in a subsequent study.

A staff of field directors will be utilized on a regional basis to assure compliance with study procedures, reliability of data, and support for the motivation of participating agencies and personnel. These regional directors, who constitute the quality control mechanism for the survey, will maintain constant communication with welfare, health, and law-enforcement agencies and personnel on state and local levels in order to interpret to them the steps of

the study, and will be available for working out appropriate adjustments of general study procedures to specific local conditions. The regional directors will check the operation of the central registries and the filling out of research schedules. They will also compare samples of schedules with case records, to which most states are ready to give access. To the extent that time is available, the regional directors will also collect systematic data on the service patterns within their respective states and sample communities, since this type of information will not be available from the schedules completed on individual cases.

In view of the nationwide scope and projected size of the study, processing will be handled by means of automated equipment. Analysis will entail quantitative description of the study cohort in terms of the study variables, and a search for significant associations and associational trends between selected variables.

The survey will require approximately two and one half years for completion. The first six months (July–December, 1966) will be used for setting up and testing procedures in participating states. During 1967 the study cohort will be recruited. Data collection and processing will proceed concurrently with recruitment and will be terminated six months after the study year. Data analysis should be completed by the end of 1968.

Several additional studies are contemplated, to be developed to the extent that resources are available:

a) A study similar in scope and pattern to the survey, but utilizing a standardized clinical interview, of persons involved in incidents of child abuse in order to shed light on possible psychological dynamics underlying child abuse and to supplement demographic and socioeconomic data collected during the epidemiologic survey

b) A study geared to reach incidents of child abuse less visible than those reported through the legal network

A major avenue for reaching such incidents will be the medical network, primarily private medical practice, and social welfare agencies.

c) A study expected to reach into the least visible manifestations of child abuse, to cases which would not come to the atten-

tion of anyone outside the abused child's family or household. One possible approach here might be clinical interviews focused on child rearing patterns in randomly selected households.

d) A set of comparative studies focused on child abuse in different cultural settings and in specific social constellations within and outside the United States in order to gain a better understanding of the role that cultural and social variations play in child abuse.

In the course of the developmental year several substantive substudies were conducted. Although the analysis of these studies has not yet been completed, certain preliminary findings can be reported:

Nationwide survey of knowledge and opinions concerning physical child abuse.—The purpose of this survey was to obtain information on public attitudes on selected issues concerning physical child abuse. The survey was designed by us, and interviews were conducted by the National Opinion Research Center of the University of Chicago. Fifteen hundred and twenty adults were interviewed during October, 1965. The sample interviewed was a standard, multistage, area probability sample to the block or segment level. At the block level, quota sampling was used, with quotas based on sex, age, race, and employment status. A quota sample of 1,500 respondents, such as the one used in our survey, has about the same efficiency as a simple random sample of 1,000 respondents. The standard error of proportion for such a sample does not exceed 1.6 percent.[5]

About 80 percent of the respondents had heard or read about the problem of child abuse and about specific incidents of child abuse during the past year. An additional 10 percent had heard about this issue prior to the past year. The major sources from which respondents learned about child abuse were: the press (70 percent), radio and television (50 percent), magazines (20 per-

[5] There are about 110,000,000 adults twenty-one years of age and over in the United States. These 110,000,000 constitute the universe sampled by the survey. The percentages quoted in the discussion may be extrapolated with 95 percent confidence to this universe within the stated margin of error of under 2 percent. An exception to this is the item concerning personal knowledge of families involved in child abuse. Accurate projections based on this item are not possible, since the same family is likely to be known to more than one person.

cent), and conversation with friends and neighbors, and so on (20 percent). Five percent of the respondents had learned about child abuse from medical personnel.

About 4 percent of the respondents had personally known families who were involved in incidents of child abuse during the past year. They were able to identify the families and to provide details concerning the families, the child, the perpetrators, and the circumstances of the incidents.

About 60 percent thought that almost anyone could at some time physically abuse a child in his care. Over 20 percent thought that they themselves might at some time abuse a child. Over 15 percent admitted that at least once in the past they were hardly able to keep themselves from abusing a child, and over 0.5 percent revealed that they had actually lost control over themselves at least once, and that they did abuse a child in their care.

Thirty-five percent of the respondents thought that a child should be removed from the care of a person who abused him the first time it happened. Over 50 percent thought that an abused child should be removed from his home only as a last resort. They believed that parents should be given a second chance and should be helped to improve the care of their children.

Twenty-seven percent of the respondents thought that persons who physically abuse children should be jailed or punished. Sixty-six percent, however, thought that they should be supervised and treated rather than punished.

Fifty-five percent thought that social welfare agencies should carry major responsibility for dealing with the problem of child abuse. Twenty-three percent thought that law-enforcement agencies should be entrusted with this responsibility. Fourteen percent thought that health agencies should be assigned this task.

Respondents were asked what they thought they would do if they learned of child abuse in their neighborhood. Forty-five percent said that they would not get involved directly with the family, but would notify a social welfare agency. Twenty-four percent said they would notify the police, but would not get involved directly with the family. Fourteen percent said that they would approach the family directly. Nine percent thought they would talk it over

with other neighbors, and 7 percent said they would keep out of it altogether, since they would not mix into other people's affairs.

Respondents were next asked what they would do if a child were abused in their presence. Seventy-six percent said that they would try to stop the abuse and to protect the child. Twelve percent said that they would not interfere, but would call the police. Eight percent would also not interfere, but would call a social agency. Three percent said they would not mix in other people's affairs and would, therefore, keep out of it.

It is important to keep in mind that the responses reported in the two preceding paragraphs reflect verbalized attitudes and not actual behavior. Verbalized attitudes tend to be influenced by dominant social values to a higher degree than actual behavior. Such expressed attitudes are, therefore, inaccurate predictors of actual behavior.

Respondents were asked for their opinions concerning publicity on incidents of child abuse. Thirty percent favored a lot of publicity, 44 percent suggested some publicity, and 22 percent objected to publicity.

Fifty percent claimed knowledge of agencies in their community that could be turned to for protection of physically abused children, and 50 percent did not know to whom they could turn.

Over 20 percent of the respondents said that they had heard about some educational program or activity concerning child abuse or its prevention, and 4 percent had actually participated in such programs.

The foregoing returns are now being analyzed in relation to selected characteristics of the respondents.

Survey of the press.—This survey examined the content of newspaper clippings collected from July through December, 1965, by a clipping service with nationwide coverage of the daily and periodic press. Clippings included reports on incidents of child abuse, editorial comments, feature articles, and readers' letters.

Press coverage is a poor measure of the real scope of the phenomenon of child abuse, since not all incidents become known to the press, and of those that do become known, only some are considered newsworthy. Moreover, the clipping service tends to over-

look some of the incidents reported in the press. Press coverage seems to be more comprehensive and the clipping service more reliable with regard to fatal incidents than to nonfatal ones.

During the six-months period reports of 412 incidents involving 502 children were received. Of these, 130 incidents involving 164 children were fatal, and 282 incidents involving 338 children were nonfatal. Table 1 compares these figures with those reported by the American Humane Association, based on a twelve-months nationwide press survey conducted in 1962.[6]

TABLE 1

INCIDENTS OF CHILD ABUSE REPORTED IN THE PRESS THROUGHOUT THE UNITED STATES

Type of Incident	*1962 AHA Survey (12 months)*	*1965 Brandeis University Survey (6 months)*
Fatal incidents		
No. of incidents		130
No. of children	178	164
Nonfatal incidents		
No. of incidents		282
No. of children	484	338
Total no. of incidents		412
Total no. of children	662	502

The foregoing figures should not be interpreted as evidence of an increase in the incidence rate of physical child abuse, especially of the fatality rate. As has been pointed out, data collection by means of press clippings is unreliable. Also, public awareness of, and interest in, child abuse has increased since 1962, a fact likely to be reflected in increased press coverage of the phenomenon.

Pilot study of incidents of child abuse reported through legal channels.—In February, 1966, a pilot study was launched in California aimed at analyzing a sample of reports received by the central registry in the California Department of Justice.

California was selected for the study since it is at present the

[6] Vincent DeFrancis, *Child Abuse—Preview of a Nationwide Survey* (Denver: American Humane Association, 1963).

most populous of the states. Furthermore, the reporting rate in California seemed higher than the rate in other states. Between September 17, 1965, when the California Central Registry was established, and February 16, 1966, nearly seventeen hundred reports had been received.

The relatively large number of incidents reported in California also offered a welcome opportunity to pretest the research schedule which had been developed for data collection during the 1967 nationwide survey.

Table 2 shows the size and the sampling ratios of two independent samples drawn at random from the 1,674 reports received by the California Central Registry by February 16, 1966. By drawing two independent samples the reliability of findings was increased.

TABLE 2

SAMPLE SIZE AND SAMPLING RATIOS OF SAMPLES DRAWN FROM CALIFORNIA CENTRAL REGISTRY OF CHILD ABUSE

Total no. of reports received	*Sample I*		*Sample II*		*Total*	
	No.	*Ratio*	*No.*	*Ratio*	*No.*	*Ratio*
1,674	279	1/6	150	1/11	429	1/4

Police crime reports concerning all cases in both samples were examined and screened against the conceptual definition of child abuse, in order to exclude from detailed analysis cases which did not fit the definition. It was found that approximately one third of the cases in each sample fit the definition.

Table 3 further classifies the nonabuse cases. About half of these cases were neglect situations, and about one quarter were incidents of sexual abuse.

Table 4 shows the geographic distribution of the cases which were classified as physical abuse. As expected, the majority of these cases was concentrated in the major centers of the population.

Each of the 139 cases which fit the definition of child abuse was traced back to the community from which it was reported, and

TABLE 3

CLASSIFICATION OF NONABUSE CASES

Category	*Sample I*		*Sample II*		*Total*	
	No.	*Percent*	*No.*	*Percent*	*No.*	*Percent*
Neglect and suspected neglect	88	50.9	47	46.5	135	49.3
Sexual abuse	36	20.8	31	30.7	67	24.5
Child stealing	15	8.7	9	8.9	24	8.7
Abandonment	11	6.4	2	2.0	13	4.7
Death (natural, accidental, suspicious circumstances)	5	2.9	4	4.0	9	3.3
Endangering life of child	6	3.5	1	1.0	7	2.6
Other	12	6.9	7	6.9	19	6.9
Total	173	100	101	100	274	100

TABLE 4

GEOGRAPHIC DISTRIBUTION OF CASES CLASSIFIED AS PHYSICAL CHILD ABUSE

Location	*Sample I*	*Sample II*	*Total*
Los Angeles	24	11	35
Los Angeles County	12	10	22
Long Beach	5	2	7
Remainder of Southern California (30 communities)	25	12	37
Total Southern California	66	35	101
Oakland	5	3	8
San Francisco	2	—	2
Remainder of San Francisco area (7 communities)	5	5	10
San Jose	5	1	6
Total San Francisco Area	17	9	26
Sacramento and Northern California (7 communities)	7	5	12
Total California	90	49	139

data on it are being collected from local health, welfare, education, and law-enforcement agencies.

Preliminary survey of reporting rates.—As a concluding fragment we present in Table 5 a set of projections of annual reporting rates for ten states and three cities. The projections are based on initial reporting rates in these states and cities during parts of 1964 and 1965. The data on which the projections are based reflect in most instances a reporting record of a few months only. The margin of error is, therefore, likely to be quite large. However, these projections represent the best possible estimate at this time.

TABLE 5

ESTIMATES OF ANNUAL REPORTING RATES OF CHILD ABUSE

States and Cities	*Total Population in Millions (1960 Census)*	*Estimated Rate per 1,000,000*	*Approximate Totals Expected for 1967*	*Upper Age Limit for Reporting*
California	15.7	65	1,300 [a]	minors
Illinois	10.0	46	460	16
Massachusetts	5.1	27	135	16
New York	16.8	22	420 [b]	16
Michigan	7.8	22	175	17
South Carolina	2.4	20	50	16
Kentucky	3.0	20	60	18
Arkansas	1.8	9	18	16
Florida	4.9	6	30	16
Rhode Island	0.9	5	5	18
	68.4	*39*	*2,653*	
New York City	7.8	40	320	16
Chicago	3.5	70	245	16
Denver	0.5	144	72	12

[a] California's population in 1967 is likely to exceed 20,000,000.
[b] New York's population in 1967 is likely to approach 19,000,000.

Supplementary Services by Volunteers in a Casework Agency

by HARRIET GOLDSTEIN

The Association for Jewish Children of Philadelphia is a multifunction child-care agency. It provides placement for children in foster homes and group residences and maintains a small institution for adolescent boys. A major function of the agency is an adoption service, and the agency also offers a complete program of care for unmarried mothers.

Founded 111 years ago through the inspiration of a single volunteer—Rebecca Gratz—the Association is steeped in the traditions of voluntarism. Program and personnel have been reorganized continuously, however, to meet the rising incidence of emotional disturbances encountered in the children in care and in their pathological family situations. Through all the changes, the thread of services rendered by agency volunteers has been steadfast, and throughout the history of the agency, volunteers have been used for a wide variety of purposes.

In recent years, the high degree of disorder noted in children and families made the agency more and more aware of new roles and points of view that had to be assumed and fulfilled:

1. There had to be greater acceptance of the agency's parenting and child-caring function. This stemmed from the actual responsibility of the agency, which ranges from dealing with the child's need for overt signs of caring to demonstrating in practice what the social worker professes.

2. As an array of placement facilities became necessary, group homes were developed, thereby increasing the burden carried by

agency personnel. This meant that staff not only had to meet the fundamental needs of children in their care but had to provide enriching cultural, social, and living experiences for them as well.

3. Foster parents required auxiliary services in order to handle the children in their homes. "Love alone" was not enough but needed to be linked with professional resources, including caseworker, psychiatrist, psychologist, and tutor.

4. Attention had to be paid to the high intellectual potential but marked learning deficits of the children; failure to do so would perpetuate their feelings of defeat and worthlessness.

5. Severely maladjusted parents cannot respond to direct treatment alone but require a variety of supportive techniques and help in managing their lives. Approximately 75 percent of all parents whose children receive our agency's services were personality-disordered people. They needed direct, obvious, concrete, and demonstrable evidence that people cared for them.

6. The community's image of children who require placement, and of the foster homes serving them, needed to be changed. Indeed, to insure even a minimum supply of foster homes, there had to be considerable "drum beating" in the community.

Reassessment of client needs led the agency to a reassessment of volunteers as an additional personnel resource. There was recognition that members of our board of directors and our active volunteers had performed many services to our clients, both directly and indirectly, and had developed a fund of experience and knowledge of techniques which could be reevaluated. It was decided that in a reorganization and broadening of the volunteer program, volunteers should be active planning participants with the professional staff.

With this conviction, then, a corps of dedicated, responsible volunteers was called together to form a Volunteer Steering Committee. It was the purpose of this group: (1) to evaluate forthrightly what had taken place in the volunteer program in the past; (2) to serve as a counseling unit for volunteer planning and programing; (3) to reinvolve other volunteers who had "gone by the wayside"; (4) to recruit new volunteers.

In two meetings, the Volunteer Steering Committee and the

professional staff determined that the agency could utilize effectively approximately a hundred volunteers. Job titles and job descriptions were drawn up, and the qualifications for each category were carefully defined. Eight classifications of service were developed:

1. *Administrative assistant:* Assist in the agency's clerical and bookkeeping departments; type correspondence with foster parents; complete special mailings; file records; train in dictaphone work; read and sort old records
2. *Shopping corps:* Periodically check prices of children's clothing in retail stores so that clothing allowances may be appropriately regulated; purchase of Chanukah gifts for children in care; shop for birthday and graduation gifts; refurbish the agency's group homes and institution
3. *Special events coordinator:* Plan and supervise group and special individual activities for children in agency residence programs, such as theater and museum outings and trips to New York; take children who live in group facilities shopping on an individual basis; plan and execute confirmation and graduation parties
4. *Case aide:* Work directly with a caseworker on an assigned portion of a case task in a specific case situation and on a sustained basis with child, foster parent, or natural parent
5. *Public relations aide:* Take part in a continuing program of recruiting foster parents; line up speaking engagements and give talks if qualified; lead discussion groups on foster care; conduct a neighbor-to-neighbor project and follow-up on a "mailvertising" campaign (a random letter campaign appealing for foster parents in a highly concentrated Jewish neighborhood)
6. *Interviewer:* Participate in a program to promote public knowledge of agency's service to unmarried mothers; talk with doctors, lawyers, and community groups
7. *Driver:* Escort children on a planned, individualized basis to meet parents, psychiatrist, caseworker, or physician; report observation of child to caseworker
8. *Tutor:* Teach individually assigned children in specific subjects in which child is deficient; work in coordination with agency psychologist and researcher.

Based on previous planning, two other points became matters of conviction. One was that each volunteer should be assigned specific tasks and should be associated with a specific staff member—caseworker, administrator, or supervisor. Only in this way could

service be insured and the volunteer have a satisfying sense of achievement in seeing how her role fit into the broader framework.

The second point was that the volunteer program could function properly only if it had the services of a trained staff person. It was recognized that the absorption of 100 volunteers into the agency's operation could require constant direction and that it was unrealistic to expect to accomplish this unless such an individual were hired for that specific purpose. Hence, a Director of Volunteers (not a social worker) was employed to supervise the volunteer program: to recruit, interview, select, classify, orient, and train volunteers; to develop program stimulation and training on a group basis; and to integrate volunteers within the total agency services.

The crux of any service program is people. In recruiting volunteers, it was determined that: (1) people with specific skills and talents were needed; (2) standards should be established and maintained; (3) careful screening and evaluation were necessary; (4) matching of volunteer to client problem or agency use was essential.

Hence, people—both male and female—were sought who could relate well to children, who could communicate easily with adults, and who had a flair either for creativity or for detail work. It was necessary to recruit those who could work well with children on either an individualized or a group basis. It was important that some volunteers have an ability to do public speaking or be able to approach the members of other professions, such as doctors and lawyers. It was made clear that volunteers were expected to be consistent in their approach and were required to maintain confidentiality.

In some categories, special talents were needed. Experience in typing, filing, dictaphone work, stenography, or bookkeeping was essential if one was to be an administrative assistant. Sales experience or knowledge of current trends in fashions and home furnishings was desirable for a volunteer who wished to qualify to serve in the shopping corps. A driver's license and a car would be useful in several categories. Tutors were expected to have a bachelor's de-

gree, preferably in education, and teacher-training experience was considered valuable. They were required also to meet the qualifications and standards set by the agency psychologist.

In recruitment, the volunteer was acquainted frankly with several other considerations. In contrast to the usual hospital or psychiatric center, the Association for Jewish Children is a small agency. Since it does not have a large number of clients it cannot utilize a volunteer on a full-time basis. Comparably, the responsibility of bringing up children is not always dramatic. It is difficult to be a parent to one's own child; it is even more difficult when other people's children are concerned, as well as grownups who must be treated as children. Results are slow, and frequently there is little glamour in the task. A volunteer needs therefore "to make peace" with the limitations of the agency program and with his assignment in it.

Although small in size, the Association is complex in scope. An umbrella of services is offered for solving child-centered problems. To service client needs most soundly, the volunteer program was designed primarily on an individual-to-individual basis. Therefore, it became necessary for the Director of Volunteers to create a development program which would mesh the volunteers' identification to a specific service category with the over-all function and purpose of the agency.

The Director of Volunteers is at the hub of coordinating and sustaining the volunteers. Requests for service are made to the Director whose first task is to recruit and match the volunteer to his particular assignment. Further, it is the Director who provides the volunteer's initial orientation and who answers his questions. She becomes the bridge between the volunteer and the staff member who defines his specific assignment and with whom the volunteer correlates his performance. Together, volunteer and staff person examine and reexamine the client's wants and together plan their fulfillment. The volunteer is apprised continuously of the scope and dimension of the client's treatment requirements so that he may fit his function appropriately into the whole of the service.

Guided by the advice and the opinion of the Volunteer Steering Committee, it was accepted that volunteers did not want to attend

endless meetings but that rather they wished to devote their energies to "doing." To insure sufficient technical knowledge while at the same time achieving balance in programing, service category group meetings are scheduled at approximately ten-week intervals. About three general meetings are planned in the course of the year to solidify agency relatedness. To keep volunteers further informed, a periodic newsletter details significant events and trends in agency life.

The responsibility for the structure of the service category meetings is shared between the Director of Volunteers and the staff member responsible for that phase of agency operation. These are practical, in-service meetings to help the volunteer better understand his role and the dilemmas of his clients. Hence, meetings with the special events coordinators are organized to instruct them sufficiently about the underlying dynamics of deeply distressed adolescents so that they may understand the children's reactions. Volunteers are informed about the children in care, their history and background, and their current patterns of functioning. Knowledge of their behavior symptoms, translated into daily living terms, gives the volunteer various insights into the significance of, for example, a shopping excursion and the child's excessive need for material objects as an attempt to compensate for love deprivation; or the importance of going to several stores and having an opportunity to select and choose so that values are established; or the sheer need to dress appropriately and attractively to enhance inner ego satisfaction.

Similarly, sessions with tutors have sought to differentiate between therapeutic tutoring and purely academic teaching. Tutors have examined learning goals and the appropriate use of relationship with the child. There has been full exploration of the significance and the uses of the monthly evaluation sheet completed by the tutors and detailing course content, attitudes, and attendance. Information culled from these forms is vital in the agency's research on correction of educational disabilities.

Public relations aides have viewed the films on foster care shown to lay groups for educational purposes and have practiced leading discussions and giving speeches to each other. Administrative as-

sistants have been made acquainted with agency policies, standards, and procedures as they affect their work in the agency. In other words, meetings are planned to be informative, clear, and brief.

The use of volunteers has provided both tangible and intangible benefits to clients and agency. Direct benefits to the agency inevitably result in direct-service benefits to clients. Four categories of volunteers—the special events coordinators, case aides, drivers, and tutors—function directly with children and parents. They provide an extension of casework and group work services; the twenty-five volunteers who do tutoring offer opportunities for educational development.

Through the help of these volunteers, children are enabled to have additional growth-producing experiences and are stimulated in their personal development. For instance, one of the girls in a group home was an avid Beatles fan. Taken to her first concert by a volunteer whom she respected, she began to reflect on the different qualities of music and to question a single value system in this field. This actual demonstration allowed productive sessions about self, choice, and values to take place both in her casework and in her psychotherapy interviews. It is questionable whether either the girl's psychiatrist or her caseworker could have afforded the time required to take this youngster to a concert, but the volunteer's act introduced a vital treatment dynamic.

Mrs. A. volunteered to be a tutor. Although she did not possess the necessary qualifications, it was recognized that she had much energy, considerable warmth, a real desire to serve, and an appreciation of disturbed children. Mrs. A. agreed to function as an escort for a nine-year-old boy in agency care who attended a public school class for emotionally disturbed children. It is her responsibility once a week to pick Robert up at school, take him to his psychiatrist, and to lunch, and return him to school. Prior to Mrs. A's acceptance of this assignment it had been impossible to keep the boy in school, for his acting out stimulated by the therapy session carried over into the classroom. Mrs. A. offered him comfort and "mothering," reaching him not only by her sustained presence, but by her direct and actual "emotional" feeding. She is an impor-

tant link and a responsible factor in the school's ability to hold Robert in class on these especially difficult days.

The three W. children are adorable redheads, the delight of their foster parents. Their mother is a limited woman, separated from her husband and struggling to maintain two other children at home. The caseworker was concerned for the well-being of these children and for Mrs. W's capacity to function. Further, the caseworker knew that the three children already in care needed to be relieved of anxiety about their mother and to be assured that she was being looked after. The caseworker arranged for Mrs. L., a volunteer, to visit the W. home regularly. Mrs. L. found that the children there needed much medical attention, but the mother was intimidated by clinic procedures and routines. Mrs. L. therefore accompanied mother and children to a clinic weekly until the children's health was restored. She advised Mrs. W. on cleaning her apartment, improving her dress, and securing physical care for herself. Subsequently, it was recognized that Mrs. W. could not parent the two children at home, and eventually, with the caseworker's support and guidance, the volunteer helped Mrs. W. accept the placement of these two youngsters. At the same time, Mrs. L. remained interested in the mother and thereby rendered continued service to the woman and to her children in care.

Example after example could be cited attesting to the direct benefits that accrue to clients as a result of their relationship with volunteers. Both children and their parents require overt evidence of caring, and volunteers are supplementary forces performing this. Some of the parents need common-sense advice and practical direction accompanied by a feeling of warmth and interest from another person. Volunteer tutors provide concrete learning tasks in the building of academic skills, and with few exceptions there has been the direct benefit of improved grades. There has been distinct value in providing adult models who stimulate learning for the sheer experience and enjoyment of it.

In the other categories of volunteer service, administrative assistants, the shopping corps, public relations aides, and interviewers perform more at the operational level. As an agency develops new service programs, necessarily there are additional responsibili-

ties that require administrative detail. A new system of cost accounting, an enlarged foster parents' activities program, or group meetings on adoption, for example, mean more clerical work and bookkeeping controls. Just as there has been an extension of the caseworker through the volunteer, there has been comparable extension of the administrative program through volunteers.

Each volunteer who relates positively to an agency serves that agency in a public relations capacity. Identified with, and informed about, a program, he becomes an ally. Conversely, if a volunteer program is carelessly organized and administered, or if the staff fails to treat volunteers with the courtesy and consideration due team members, a poor image is created and a disservice is rendered.

There is little question that the volunteer is "here to stay." Because there are serious manpower shortages, one may be tempted to substitute volunteers for professional staff. Frequently, too, volunteers are used on the assumption that they are "money savers." While volunteers provide many hours of valuable and otherwise costly manpower, it is clear that they have not replaced, nor have they diminished the need for, a full complement of trained personnel. Rather, they have supplied enhancing and enriching adjunctive services to clients who have many unfulfilled needs.

The professionally trained social worker has "come into his own" within the past fifty years. The resurgence of volunteer use now challenges the caseworker to reexamine the principles and practices of his profession. In a recent article, it is noted that these principles and generalizations "are often so incorporated in his daily practice they are hard to make explicit, even to himself, as they have to be in dividing a shared relationship" with a volunteer. The thesis is further developed:

> There is nothing reprehensible in the reluctance of caseworkers to undertake such a new way of working. It is hard; at least in the early stages of experimenting, it takes more time, not less; it is impossible to be certain of the results; it requires the self-discipline to observe and evaluate each experience in common terms that can be analyzed with the experience of others in order to produce generalized results. Caseworkers will be able to make the necessary effort only if they believe the results will

perhaps make a measurable contribution to the amount and quality of service that the agency can render.[1]

It is obvious that the common denominator that binds all helping persons together is the individual whom we serve. The day when the professional can "go it alone" is long since gone. The skills and talents of many people, properly matched and deployed, are essential to insure proper service.

[1] Mary R. Baker, "Approaches to a Differential Use of Staff," *Social Casework*, XLVII (1966), 232.

Illegitimacy Recidivism among AFDC Clients

by BARBARA B. GRISWOLD, KERMIT WILTSE, and ROBERT ROBERTS

HARDLY A DAY passes without headlines about the increase of illegitimacy in the United States and the alleged concentration of unwed mothers in the Aid to Families with Dependent Children (AFDC) program. The specter has been invoked of a rising tide of illegitimate children born to immoral women, fathered by irresponsible men, and supported by the hard-working taxpayer.

Those women who are receiving aid for more than one illegitimate child have been singled out for special condemnation. The availability of aid itself has often been suspected of encouraging repeated illegitimacies, the accusation being that a woman will have a second, a third, or even additional illegitimate children, in order to get more assistance.

The administrators of welfare programs have received their fair share of the criticism, often being accused of doing nothing to halt the increase in illegitimacy. Logically, it would appear impossible for public welfare personnel to prevent a woman from having her first illegitimate child, inasmuch as she does not become known to the agency until after she has become a parent. However, approximately one half of the women who receive AFDC for one out-of-wedlock child continue to bear children without benefit of marriage. Thus, this portion, which constitutes approximately one fourth of the total AFDC population, contains women who *are* known to welfare personnel prior to the birth of an illegitimate child. Theoretically, at least, they are susceptible to interventive

treatment aimed at reducing the incidence of illegitimacy. Considering the potential importance of this group of women, it is remarkable that nothing is known about them. For example, are they different from women who are receiving aid for one illegitimate child, but who will never have another? If this question should be answered in the affirmative, it would open the way toward the possibility of informed preventive methods.

Our contacts with welfare agency staff in California indicated a widespread belief that there are differences between the "once-only" and the so-called "career" unmarried mothers; however, the workers were unable to articulate the differences. Much frustration was evident in the attempts of workers to intervene with their clients in order to prevent subsequent illegitimate pregnancies. Thus we were convinced that welfare personnel in general share the attitude of the lay public that these repeated pregnancies are indeed unfortunate and that the goal of preventing them should have high priority. Whether or not this attitude is shared by the AFDC mothers themselves was unknown.

With financial support from the California State Department of Social Welfare and with the cooperation of the Richmond office of the Contra Costa County Welfare Department we began a factual study of unwed mothers on AFDC. Our eventual goal was a sufficient understanding of repetitive illegitimacy to be able to take a stand as to whether or not it is undesirable behavior and, if so, to be able to predict potential repeaters and to intervene effectively. A more limited goal was set for the present research. We set out to describe the differences between those women receiving AFDC who have *not* repeated the pattern of illegitimate childbearing (uniparae) and those who *have* had multiple out-of-wedlock children (multiparae). Since an earlier case reading indicated that the average length of time between the illegitimate children of the multipara was two years, we established the criterion of three years as the least amount of time which must have elapsed since the birth of the unipara's one illegitimate child. This criterion helped to assure that most of the women in our group of uniparae were true uniparae, not merely multiparae who had not yet had time to bear a second illegitimate child.

In the records of the office from which our sample came, Negroes, as is probably usually the case, are overrepresented among the multiple repeaters; however, illegitimate births are sufficiently frequent among white clients to warrant study. When case records were examined in 1963, 41 percent of the white women with illegitimate children were repeaters, whereas 53 percent of the Negro women with children out of wedlock were repeaters.

It is important to emphasize at this point that most of these women are not "unmarried mothers" in the usual sense. We found that approximately two thirds of the AFDC mothers with illegitimate children had been married at some time in their lives and that 57 percent had borne legitimate as well as illegitimate offspring. We also found that whether or not they had been married or had legitimate children was not related either to race or to the number of their out-of-wedlock children. Thus at the onset of the study we knew that the multiple repeater in the AFDC caseload was not prompted simply by the lack of opportunity to bear legitimate children. What were the motivations that influenced her behavior? We hoped that by comparing her with women similar to her in every way except that they had not had repeated illegitimate pregnancies, we could find some significant answers.

The clients we studied were forty white and forty Negro women—twenty uniparae and twenty multiparae in each race, all randomly selected from their respective groups in the caseload. This particular design enabled us to ask, first, whether within a single race uniparae and multiparae were different from one another and secondly, whether the pattern of differences between uniparae and multiparae would vary between races.

There is little relevant research in the literature. Pearson in 1956 reported that mothers of several illegitimate children were less intelligent than the mothers of one.[1] Vincent has found that recidivists are less well socialized than "once-only" unwed mothers.[2] Other research has focused on illegitimacy rather than on

[1] J. S. Pearson and P. L. Amacher, "Intelligence Tests Results and Observations of Personality Disorders among 3,594 Unwed Mothers in Minnesota," *Journal of Clinical Psychology*, XII (1956), 16–21.

[2] Clark Vincent, *Unmarried Mothers* (New York: Free Press of Glencoe, Inc., 1961).

recidivism. Thus our data collection was largely unguided by prior research and explicit hypotheses. Actually, what we did was to ask in a uniform way every question any of the research staff could possibly think of that might be relevant to the subject. Our attempts to learn as much as possible from these women resulted in a ninety-page standardized biographical schedule which was administered by experienced, professional social workers. On the average, it took approximately three hours to complete. Basically, the rationale behind the schedule was akin to that of the social work case history. The schedule began with a description of the circumstances, community, and family composition of the respondent at the time of her own birth. It then focused on her current living situation and returned to her childhood. Data were collected on her family's geographical mobility, the respondent's living mode as a child, the structure of her family, and a description of her parents and her interaction with them.

In addition to the interviews a complete battery of psychological tests, averaging three hours to complete, was administered by qualified psychologists. The tests included the Rorschach, MMPI, CPI, WAIS, and a relatively new measure of superego strength. The whole procedure required one home visit and three or four office visits.

Obviously, research of this magnitude requires quite a bit both from the research staff and from the clients, who must subject themselves to intensive and sometimes embarrassing inquiry. Considering how much was being asked of these women, we feel that we obtained very good cooperation. Our initial approach to these clients was by a letter in which we introduced ourselves as researchers from the University of California School of Social Welfare who were interested in certain women who were receiving AFDC. No mention was made of our concern with illegitimacy. The clients were told in the letter that the study had no connection with the welfare department, and they were assured that their participation would in no way affect their AFDC payments. They were also told that if they did participate it would mean that one visit would be made to their homes, they would make three trips to our office, and we would pay them five dollars for each office

visit. In addition, we said, a five-dollar bonus would be granted if they completed everything, including two of the paper and pencil psychological tests which were sent home with them and were to be returned to us at the time of their last visit.

Twenty-four of the women initially contacted by letter refused, either by telephone or at the home visit, to participate in the study. Those who refused included seven white unipara, nine white multipara, seven Negro unipara, and only one Negro multipara. To what extent the refusals have biased our results is not clear. Why the women refused to cooperate is also unclear. Whether or not they would respond positively to a different interviewer or to different incentives is not known, but we feel that it is pretty unlikely. In several cases where a different interviewer followed up the first one in an attempt to secure participation, the efforts were singularly unsuccessful. However, with the exception of one who did not return her psychological tests, every woman who made the first office visit finished the series, and it was remarkable how few appointments were broken without advance notice. This was probably due to the social worker's successful attempts to make the clients feel that their contribution was important to our work and that our work could be very helpful to other women like themselves. This latter incentive, in fact, seemed equally as useful as the monetary one in enlisting cooperation.

Analysis of our data has proceeded in several ways. A preliminary inspection of our results indicated that our sample was an homogeneous one and that few single schedule items would differentiate between recidivists and nonrecidivists. The decision was made, therefore, to divide the interview schedule into clusters of items designed to tap important areas of the respondents' experiences. The decisions as to which conceptual areas should be focused upon and which individual items were to be included in a cluster were made by a rational method. That is, the researchers purposely did not become familiar with the data until after the clusters were developed.

By and large, our two major predictions have received support. The results indicate that there are, indeed, differences in personality structure between women who have a single out-of-wedlock

child and those who repeat. Support has also been obtained for the hypothesis that illegitimacy recidivism is a different phenomenon for white women than for Negroes. All in all, however, we have been impressed with the homogeneity of the four subgroups and with the failure of many truisms to hold true for this AFDC sample.

In our reading, thinking, and talking with welfare personnel one explanation of illegitimacy recidivism appeared over and over again. This was the suggestion that certain cultures are more tolerant than others toward illegitimacy. This explanation has been offered especially in regard to the high rate of Negro illegitimacy. Proponents of this theory apparently assume that a Negro woman will allow herself to become pregnant out of wedlock, will bear an illegitimate child, and will rear that child without a legitimate father because *all* such behavior is tolerated by the value system prevalent among her subculture, while a white woman will refrain from such behavior because of the greater social censure she would receive for any one of these acts.

Because there was reason to believe that values related to the phenomenon of illegitimacy are anything but one-dimensional, we studied as many related values as possible, including the following: those values in regard to extramarital sexual behavior which might result in an illegitimate child; those concerned with birth control or abortion which might prevent such a child from being born; those centered on adoption which might prevent such a child from being reared without a legitimate father; as well as, of course, those values directly related to illegitimacy.

To the extent that a woman has no negative evaluation of illegitimacy, she will be relatively comfortable in her role as an unwed mother and will feel that her subculture explicitly sanctions her behavior. This appears to be the explanation of Negro illegitimacy offered by the extreme cultural view. On the other hand, it is possible that subcultures might differently value a behavior intrinsically related to illegitimacy but not sanction illegitimacy itself. In this case there would be a high rate of illegitimacy, but the women concerned would not feel content in the role of unwed mother.

The present data relevant to these questions indicate that the extreme cultural interpretation which attributes differing rates of illegitimacy purely and simply to differing values toward illegitimacy is an oversimplification. When a separation is made between behavior and attitudes toward behavior, the data do not support the theory. Although the Negroes were more likely to have had parents and siblings with illegitimate children than were the whites, they were not more likely to hold permissive values toward illegitimacy.

We found that the Negro women in this sample did not judge extramarital sexual behavior more leniently than the whites. In fact, contrary to the findings of other research, the Negro clients in this study did not appear to behave any differently from the whites with regard to extramarital sex.

Another potentially important value area, since the phenomenon we are studying includes the rearing of illegitimate children, is the attitude toward adoption. Indeed, we found that the Negroes in our sample were far more opposed to adoption than were the white women.

The findings regarding birth control and abortion revealed no consistent race differences, although the whites did consider one item regarding the use of birth control as more wrong than did the Negroes.

In summary, the Negro AFDC mothers appear to be no more tolerant than whites toward sexual practices which would increase the possibility of conception out of wedlock. They are, if anything, slightly more tolerant toward birth control practices. Both races are intolerant of abortion. And finally, they share similar attitudes toward illegitimacy. It is difficult to see, then, how race differences in attitudes alone could account for the greater probability of the *birth* of illegitimate children among Negroes than among whites. On the other hand, Negroes are far more opposed to the possibility (unlikely for them) of adoption, which means that one could explain the much higher probability of their *rearing* their illegitimate children on the basis of their value systems.

When we look at the relationship of values to recidivism, additional factors are highlighted, and the pertinent questions are:

How did the values held by their subculture affect the women who bore and kept an illegitimate child? Was there any relationship between their recidivism career and the effect on them of their subcultural values? How were they treated by the people around them? Were they easily tolerated, or were they subjected to the prejudicial treatment given a "deviant"? Was the treatment of women who had one illegitimate child different from that of women with more than one? Most importantly, were there race differences in the kind of treatment accorded these women who were rearing their illegitimate children?

Three items on the schedule tapped their perceptions in this area. For the multiparae the questions considered were those asked about their first out-of-wedlock child. The remarkable thing is the almost uniform agreement by *all* these women that they did *not* receive intolerant treatment from the people around them. Three fourths of the sample insisted that there was no change in their reputation in the neighborhood, that their friends did not respect them less, and that there was no gossip when it first became known that they were pregnant out of wedlock.

Either these answers represent massive denial on the part of these women, or there are remarkable differences between their subculture and the stereotype of the middle-class subculture held by the investigators engaged in this research. This is certainly an area which needs further study. At any rate, the fact that there were no race differences in these findings again raises a question about the adequacy of explaining the high rate of illegitimacy among Negroes on the grounds of cultural values.

It is also important to note that the perceptions of how they were treated by their friends and acquaintances did not differ between the uniparae and multiparae of either race. Such treatment, therefore, apparently could not have affected the illegitimacy careers of the women involved in a different manner.

Another source of information—the psychological test findings—also indicates that the "cultural-values" explanation of illegitimacy is an oversimplification. The MMPI and CPI both indicate that the Negro *uniparae* are far more adequate psychologically than the other three groups. Sixty percent of the Negro uniparae

scored entirely within the normal range of the MMPI, whereas only 15 percent of the other three groups fell within that range.

The fact that the Negro *multiparae* are functioning extremely poorly, are weighed down by inertia, and are singularly unhappy raises a serious question about the so-called "tolerance" of the Negro community. Whether or not the psychological malfunctioning is taken to be a cause or an effect of their being multiple illegitimate childbearers, it is inconsistent with the notion that these women who repeatedly bear illegitimate children are an integral part of the Negro community and that their behavior is fully sanctioned. Unless the behavior were deviant it is hard to see why it would be engaged in only by the less-than-adequate members of the community. The test findings also indicate that Negro girls who are quite well adjusted and well socialized can and do bear and rear a single illegitimate child.

At first sight it might appear that a well-adjusted white girl cannot so easily have a single illegitimate child. Further consideration, however, leads to another interpretation of the difference in psychological health observed between the white and Negro unipara in our sample. Many studies have reported that the white women who keep their illegitimate children are less well socialized and in general less psychologically healthy than their peers who have released their children for adoption. Thus it is likely that the better socialized white women with one illegitimate child were excluded from our sample by virtue of having given up their children for adoption. This is an important possibility and points to the complexity inherent in this kind of data. Behavior must be evaluated, not only with regard to the value system dominant in the core culture and the reference group of an individual, but also with regard to the opportunity structure provided.

Cultures as well as individuals recognize that anyone can make a mistake, and institutionalized means usually offer a measure of redemption. Often the individual who is able to rise above his mistakes is held in high repute both by his neighbors and by himself. This appears to have been the fate of the Negro uniparae. The white uniparae, on the other hand, have not fared so well. It is suggested that this fact is best understood with relation to the fact

that the white women in this sample have *chosen* to rear their illegitimate children. This in itself is a deviant act in the white culture but not among Negroes. The white woman has at her disposal the culturally sanctioned means of adoption through which she can redeem herself for her behavior. Negroes do not often have such a means available, nor is adoption culturally sanctioned by them. The Negro woman who has an illegitimate child, therefore, has little opportunity to redeem herself in the eyes of herself and her peers except by raising the child and not making the same mistake again. The white woman, on the other hand, not only has the values which would lead her to place her child for adoption, and the opportunity, but she is actually performing a less deviant act if she does so than if she keeps her child. It is likely that the act of placing her child for adoption serves as a redeeming factor for many a white girl; it may be seen as a sacrifice, something which is done for the child's sake. This act, then, is more likely to appeal to the better socialized white girl—the individual who shares the values of her peers, cares about their good opinion, and has the ability to delay the gratification of child rearing until such time as it receives social sanction. These women were not sampled in the present study, and thus our unipara groups really are not comparable.

This problem of sampling obviously affects all the data collected and should be kept in mind when evaluating other results. Throughout this report, care has been taken not to cite racial differences unless they were found in both the uniparae and the multiparae comparisons.

The concept of social heredity has provided another major hypothesis about illegitimacy recidivism. It has been reasoned that there may be a distinct family system, deviant from the family system of the majority culture, which contributes to a social heredity of multiple illegitimate childbearing.

By and large, this hypothesis was not borne out by the data. When the community of origin (at the time of subject's birth) was evaluated, several measures of community isolation from the core culture did not differentiate the four groups. We also failed to support the commonly held view that illegitimacy is related to

an extended family system. Our data revealed overwhelmingly that all four subsamples were born into, and now live in, nuclear families. Broken homes also were not related to race or to recidivism, although 61 percent of the mothers were from broken homes.

It would seem, too, that a case cannot be built to support an explanation based upon historical illegitimacy. None of the white respondents and only 10 percent of the Negroes reported being born out of wedlock themselves. Another 10 percent of the Negroes and one white client reported having siblings who were born out of wedlock. However, these items were felt to be fairly unreliable, since parents are apt to conceal a child's illegitimate status from him.

When one turns to illegitimate childbearing among siblings of the respondents, a somewhat different picture emerges. There is a large difference between whites and Negroes. Among whites 11 percent of the uniparae and 16 percent of the multiparae have siblings with illegitimate children; among Negroes, comparable figures are 60 percent of the uniparae and 69 percent of the multiparae.

The much higher percentage for Negroes seems to have importance. Assuming that these statistics are more reliable than those on the parents, there is some support for the thesis that illegitimate childbearing is an historical pattern among some Negro families. However, this family pattern of illegitimate childbearing does not reveal significant differences between unipara and multipara and thus does not seem to be associated with recidivism.

Another often heard explanation for the high rate of illegitimacy in some groups is the prevalence of "child-shifting" patterns. It has been argued that the availability of other family members to care for the children fosters illegitimacy. This explanation is apparently not relevant to these women. On the whole, fewer of these clients have children living away from them than lived away from their own parents. When legal adoptions and children involuntarily placed in institutions are omitted from consideration, only fourteen mothers in our sample have placed children outside their home, and some of these—for example, legiti-

mate children living with their natural fathers—may have been placed on a somewhat less-than-voluntary basis. Moreover, the often reported practice of child shifting among Negroes is not at all evident in our sample. In fact, Negroes were less likely to have children placed outside their homes for any reason—including incarceration in a penal institution—than the whites.

Socioeconomic status proved to be an important variable. Because of the high degree of homogeneity among the respondents, a refined scoring system was not feasible. Consequently, we used a simplified score based on whether or not the respondent's parents had finished high school and whether or not the father's major occupation was skilled or above. Using this measure we found that while the white unipara had been reared in families with a higher socioeconomic status than that of the white multipara, there were no differences between Negro unipara and multipara. Also, both Negro groups came from families with a lower socioeconomic status than that of both white groups. We find it somewhat of an enigma that socioeconomic class is related to illegitimacy recidivism in a way that might be predicted, at least for white clients, but that many of the variables mentioned previously which are usually associated with socioeconomic class are not so related.

In addition to broad social factors there are intrafamily factors which might be expected to predispose the individual toward illegitimacy recidivism. Again, many of our implicit hypotheses were not confirmed.

First an over-all measure was designed to indicate the relative presence or absence of emotional deprivation while our clients were growing up. This measure did not differentiate between groups. Also, several attempts to evaluate the closeness, continuity, and appropriateness of the mother-child relationship failed to discriminate. However, these measures did indicate that the Negro unipara seemed to have had a better relationship with their mothers than did the women in the other three groups. These data were consistent with the psychological test data which showed the Negro unipara to be the best adjusted.

Information about the respondents' fathers was often vague or

nonexistent. For this reason, we had to resort to subjective ratings rather than use a more refined measure. From reading the records a rather gross set of categories was developed which allowed the placement of each respondent into one of three possible types of father-daughter relationship. One type was the "balanced" relationship, characterized by a quality of warmth without conflict —a relationship that matured with the child. To warrant this label there also had to be evidence that the respondent not only had freedom to separate herself from her father, but had in fact done so without undue conflict.

The second type of relationship was termed "limited." This label described father-daughter relationships which were limited in interaction, in which the father was uninvolved with the respondent, or in which the father was absent and there was no long-term father surrogate to replace him. The emphasis in this category was on a lack of content, whether positive or negative.

The third type of father-daughter relationship, the "conflictual," was described as marked by a high degree of stormy emotional involvement. Cases in which there was evidence of longing for a nonexistent or a shadowy father would not be classified as "limited." In this category there had to be actual as well as fantasied involvement. Most of these relationships were neurotic, with evidence of much ambivalent feeling.

The results of this phase of the research showed almost a complete lack of "balanced" father-daughter relationships. Only three Negro respondents, and none of the whites, earned such a rating. The important differentiation thus became whether the respondents had "limited" or "conflictual" relationships with their fathers. It was found that the white unipara were significantly more likely to have had "conflictual" relationships, whereas the white multiparae were more likely to have had "limited" relationships. There were no significant differences between racial subsamples or between Negro unipara and multipara.

Since we were interested in discovering any disruptive influence in our clients' lives, we also investigated the geographical mobility of their families. We found that among Negro clients, the multi-

parae had not only been exposed to more frequent long-distance moves, but were more likely than the uniparae to have made a major move to California during a period of their lives (between ages six and eighteen) crucial for the integration of community socializing influences. The Negro uniparae came to California either before or after these ages. There were no racial differences nor was there a difference between white uniparae and multiparae.

Leontine Young has discussed a type of unwed mother who frequently has a succession of out-of-wedlock children. She describes them as "socially disorganized girls who have no standards of their own and little control over their impulses. . . . Becoming an unmarried mother is only one incident in a life history that is largely chaotic." Often, she writes, these girls "grew up in homes characterized by the same lack of social and moral standards which they suffer from." [3]

As a test of whether the multiparae were more likely than otherwise to come from families characterized by a lack of social and moral standards, a cluster was designed to evaluate the conformity or deviation of the respondents in three areas: whether or not either or both parents were heavy drinkers, whether or not either or both parents had been in jail, and whether or not there were illegitimate births in the family. Analysis of the data revealed that the Negro multiparae came from families with more social deviation than did Negro uniparae. There was no difference between the white uniparae and multiparae nor between races.

Since sexual behavior is a core component of the subject under study, and patterns copied from parents could be decisive, we attempted to assess the nature of the sexual behavior of the respondents' parents. A majority of the women in all four groups reported sexual conformity on the part of their parents. They also thought their parents set a good example with reference to sexual behavior. Here, however, there was a significant difference between uniparae and multiparae among the Negro respondents. The Negro uniparae more often than the multiparae thought that their parents had set a good example. It was clear, however, that in many cases the multiparae thought the parents had not set a good

[3] Leontine Young, *Out of Wedlock* (New York: McGraw-Hill, 1954), pp. 87, 88.

example because they were too rigid and moralistic rather than because they were too promiscuous.

Two other important intrafamily influences were religious experience and sex education. Religion was evaluated in two ways: the importance of religion to the client, and the amount of exposure she received through her parents sending her to church and going themselves. It was found that Negro multiparae were exposed to less religious influence than were Negro uniparae, although they did not differ in the importance that religion played in their lives. In contrast, the white multiparae felt that religion was less important to them than did the uniparae, but they did not differ in the amount of religious exposure they received. The present influence of religion on the respondents was also evaluated. There were no significant differences in present religious attitudes between the uniparae and multiparae of either race. Differences between the races were significant, however, in that religion seemed to have less importance for whites than for Negroes at the present time.

Our assessment of sex education evaluated both the adequacy of pertinent information and the source of such information. We found that while Negro multiparae had been given a significantly poorer sexual education than the Negro uniparae, no consistent differences occurred between races or between the white groups.

Another major explanation of illegitimacy and, by inference, of illegitimacy recidivism has been the intrapsychic one. I want to emphasize that data from psychological testing in this context could never be used to answer the question as to what personality factors caused the recidivism. This is true because the psychological factors in this study are being measured some time after the phenomenon took place. Although we might speculate that certain personality traits were also present before the multiple out-of-wedlock pregnancies, we simply cannot demonstrate it with the design of the present experiment. On the other hand, the combination of the psychological factors now present together with the early life history data can, we believe, begin to answer such a question.

The psychological test results have been more fully presented

elsewhere.[4] In brief, they indicate that the Negro multiparae tend to be less intelligent than the Negro uniparae and to feel overwhelmed by their own feelings of inadequacy; they have no sense of self-direction, no ambition, and very little sense of self-worth. They feel embarrassed and restrained with other people and are generally mistrustful of offers of help.

As often happens with people who do not feel that they control their own destiny, the Negro multiparae have, in a sense, turned away from the unpleasant reality with which they are surrounded. Their withdrawal, in turn, exaggerates their sense of being overwhelmed; and their feelings of self-alienation are intensified. Since they have stopped looking for ways in which to cope, their feeling of being unable to control their destiny is verified. They project responsibility for the effects of their own actions. They resort to "magical" thinking, attributing events, both good and bad, to fate.

It is quite likely that a crucial period in the emotional development of a typical multipara occurred during and after her first illegitimate pregnancy. The Negro multipara already suffered from low self-esteem before she became pregnant. Her negative feelings were probably related to the social deviance of her parents, her own inability to respect them, and her lack of opportunity for the continuous socializing experiences of the broader community. At any rate, it is probable that her negative feelings were then reinforced by the "sin" of becoming pregnant out of wedlock.

Such feelings of inferiority are possessed by most of us but are usually experienced as ego alien; that is, we attribute them in some vague way to an experience outside our core of self—we either fight them or we ignore them in our efforts to adjust to our environment. Although we may *feel* inferior and often powerless, we do not *act* as though we were. We go about correcting our mistakes and making a world for ourselves. There are indications that the Negro uniparae have done just this. They have probably intensified their efforts at self-control (a supposition that is sup-

[4] Barbara B. Griswold, Kermit Wiltse, and Robert Roberts, "Some Personality and Intellectual Correlates of Repeated Out-of-Wedlock Childbirth among Welfare Recipients," *Journal of Clinical Psychology* (1966).

ported by their CPI self-control scores, which were higher than those of a random sample of AFDC women). They have become rather rigid and defensive, but they have not really intensified their moral code, which remains similar to that of the multiparae.

These adaptive efforts, although they fall short of some ideal of good mental health, are successful for the uniparae, as is attested by their greater feeling of well-being and their superior ability to cope with their life situations. The multiparae, on the other hand, seem to have reacted to the crisis of an illegitimate pregnancy by an intensification of their feelings of inferiority and shame. Such feelings seem to have been incorporated into the very core of their sense of self. They have, in a sense, taken on what Erikson calls a "negative identity." One finds that although they do not like it, they are not really surprised that they continue to bear illegitimate children. They see it as an act of fate. In fact, there is a strong likelihood that their most important sense of identity is that of an "unwed mother." A similar phenomenon is familiar to workers in psychiatric hospitals who often see young patients crystallize their sense of identity as that of "mental patient" or "schizophrenic." What must be stressed is the way in which such an identity, although crystallized out of the personal experience of the past, must necessarily shape the course of the future.

It seems clear that a woman who has developed such a negative identity, together with its excruciating feelings of shame, would be poorly disposed to reach out for help. Believing herself to be the woman she sees reflected in the public stereotype of the unwed mother, she is unlikely to request or insist upon the kind of help which would enable her to rise above her situation. Since the concept of "reliefer" may well provide an additional aspect of her identity, she may accept relief in the form of AFDC; she may even unconsciously exaggerate her feelings of unhappiness and helplessness in order better to fit the role of welfare recipient. Without exceptional reaching out on the part of the agency, she is unlikely to be able to utilize its resources to escape what she sees as her destiny—the bearing of illegitimate children.

Another way in which the personalities of the Negro multiparae may contribute directly to their careers as recidivists can be seen in

their attitudes toward, and use of, contraceptive methods. Almost without exception birth control is acceptable to, and even valued by, these Negro multiparae; however they obviously do not use it effectively. This paradox is not too difficult to understand. First of all, the multiparae did not acquire adequate information regarding sexual behavior early in their lives. Furthermore, considering their fatalism, it is not surprising that they have not subsequently obtained and implemented knowledge about birth control. People who do not believe they can affect their own destiny are unlikely to try to do so.

It also needs to be emphasized that the effective utilization of most birth control methods requires a degree of self-control and forethought which is simply not characteristic of individuals who have been raised in the poverty-ridden environment common to all these women, both uniparae and multiparae. Even the consistent—not a day to be skipped—use demanded by the much-lauded pill demands that an intense degree of attention be paid to the matter of birth control. In a group of women whose daily life is constantly disrupted by financial, physical, and emotional crises, it is to be expected that attention will often be diverted from birth control to more immediately pressing problems. It seems totally unnecessary to claim that women in such situations who fail to use preventive methods regularly are either unusually weak in impulse control or are unconsciously driven to become pregnant out of wedlock. There is no present indication that either description applies to the Negro multiparae in general, although they might certainly apply to a few such individuals.

Although birth control is definitely indicated, the routine use of birth control education without accompanying supportive treatment is not suggested because the feelings of powerlessness in the individuals who need help the most and their projection of responsibility for their fate will very likely prevent them from utilizing the information.

Among the white women, both test and interview differences between the unipara and the multipara are so few as perchance to be due to chance factors alone. The biased selection of only those white unipara who choose to raise their children has already been

mentioned as a possible reason for the lack of difference between those who appear in our sample. There were absolutely no MMPI or CPI or intelligence test differences between the two white groups. One area in which there are consistent and significant differences was the superego measure, and there only on content related to sexual behavior. White unipara consistently judged any sex outside marriage, no matter what the extenuating circumstances, to be more wrong than did white multiparae. The other area in which there tended to be consistent differences was that of measured femininity. In fact, the white unipara could be described as "ultrafeminine." Both white uniparae and multiparae are a rather delinquent group of women; however, it would seem that the uniparae's ultrafeminine orientation, which includes strong conformity to sexual mores, must serve to restrict their acting out to other channels than those which would expose them to the risk of repeated out-of-wedlock children. Also, perhaps the limited father-daughter relationship among the white multipara has predisposed them to become involved with men who will also provide them with only a "limited" relationship. This possibility, combined with their lack of moral prohibition against sex and their general unconcern about what others think of them, could explain their repeatedly bearing children out of wedlock. All in all, however, we have not gained much understanding of the white recidivists.

Choices to Be Made in Social Work Education

by KATHERINE A. KENDALL

TODAY'S INSISTENT DEMANDS and tomorrow's insatiable needs for more and better trained personnel in social welfare require no description. Statistics abound to prove, paradoxically, that "the Great Society," while ushering in the "good" that social work has so long desired for the nation, has presented the profession with almost intolerable burdens. It is obvious, for social work as for all the service and helping professions, that even the accelerated reproduction of one's own kind does not and cannot, either qualitatively or quantitatively, solve the manpower problem. There are choices to make, and since choices have consequences, we must determine as clearly and unequivocally as possible where we wish to go. Out of our great need and obligation to respond constructively to challenge it is easy to be guilty of the grossest self-deception in playing what becomes a numbers game. Everyone wants both quantity and quality in satisfactory measure, but to achieve this end much more is needed than the hyphen that links quantity with quality in our discussions of the manpower situation. We shall need to choose solutions that lead to quality as well as to quantity.

The vast dimensions of the problem have already been brought home to us. We applaud the positive action of the board of directors of the Council on Social Work Education in extending "the range of its concerns more vigorously, both in principle and in practice, beyond its continuing core responsibility for the advancement of professional education to the broader scope of train-

ing and education to meet all social work manpower needs." [1] We rejoice in President Johnson's recognition, in a message to Congress on March 1, 1966, of the shortage of social workers and his request to Secretary Gardner for recommendations for remedial action.[2] We join in the call for bold and imaginative approaches. We hope for an early resolution of the problem, but as we review the possible courses of action, we are caught between the suspected expediency of certain immediate solutions and the frustration of moving too slowly and perhaps being left behind if we take time to chart long-range strategies. It is my thesis that early solutions need not and must not be divorced from long-range educational strategies; and that a certain strategy proposed for the future could yield desirable and practical answers for the manpower problems of today *and* the long tomorrow.

The architect of the strategy is John W. Gardner, Secretary of Health, Education, and Welfare. His picture of where social work education should be in 1990 was painted in bold and imaginative strokes at the opening session of the 1966 Annual Program Meeting of the Council on Social Work Education. A few quotations will outline his proposal:

I suggest that we project ourselves into the future about a quarter of a century. If you are using the same crystal ball that I am, you will see the following things quite clearly.

First, the universities will have established themselves as immensely important nerve centers of society. The inner city of the university will concern itself with the basic fields of science and scholarship at both undergraduate and graduate levels. And that inner city will be ringed with great and powerful professional schools which will serve as the bridge between the university and the rest of the community, between basic and applied knowledge, between the idea and its uses.

Among these professional schools, the school of social work will be one of the most important. We cannot be sure that it will be *called* a school of social work, nor can we describe the curriculum. But it will be a legitimate lineal descendant of present schools.

Like all of the great professional schools of 1990, it will have extremely close ties with the basic fields of science and scholarship in the university—in this case, with the behavioral and social science fields.

[1] Katherine A. Kendall, "Issues and Problems in Social Work Education," *Social Work Education Reporter,* XIV, No. 1 (1966), 15.

[2] See *Social Work Education Reporter,* XIV (1966), 1.

Indeed it will not be ranked as a distinguished school of social work unless it is associated with an institution in which those fields are strong.[3]

In 1990, Secretary Gardner's crystal ball reveals, there will be a "great complex of gleaming buildings"—a social work center which has become a "focal point for teaching, research, continuing education, setting of standards, and intellectual stimulation for personnel at every level and in every subdivision of the occupations concerned with social service."

He foresees volunteer work, typified by such programs as the Peace Corps, VISTA, and student service projects, becoming more and more meaningful to Americans of all ages who are eager to serve others. And he looks to social work professionals and schools of social work for the guidance and standard-setting that such "amateur" work requires.

Perhaps even more significant is his idea that the school of social work of the 1990s will be "the catalyst in fusing the worlds of research, teaching and community service" and will serve as "a powerful influence for the unification of services to people." He sums it all up by describing this university-based social work center of the future as a coordinating force, "a nerve center for pulling together programs and agencies and professions" within a broad frame of social welfare and action.

And he gives us the challenge: "The peaks lie ahead of you—but whether you scale them depends on your own vision and boldness."

This is heady stuff. Dazzled by the dream, we can write it off as extravagant and utopian or we can set about putting the forces of change to work for us in the directions described by Gardner. If we accept the latter course, our choices become more complicated, but our educational answers to the manpower problem become infinitely more significant. In this context, we must decide now that certain tasks are imperative.

1. We must ensure that the students we recruit now will be capable of contributing to and actually building the social work education centers of the 1990s.

[3] John W. Gardner, "Remarks," *Journal of Education for Social Work,* II, No. 1 (1966), 6–7. All subsequent quotations are from the same source.

2. We must begin now to prepare faculty members and potential faculty members to play a different and a more complicated role within the universities.

3. We must nudge new schools to move in the direction of a new and still largely undefined relationship with the social and behavioral sciences, with other professional schools, with social agencies and community leaders.

4. We must work at the national level on new approaches to curriculum building, with a view to establishing strong connections with what Gardner calls our "basic scientific and scholarly fields" and relating them in a meaningful way to research and practice in social welfare.

5. We must urge our strongest established schools to move more rapidly into new and experimental patterns of relationship with the basic scientific fields, with allied professions, and with social work practice along the lines of the Gardner model for the social work education center in 1990.

6. We must cultivate at the national level and within each university all possibilities for joint effort with other professional groups, particularly in the fields of health and education, to arrive at cooperative and composite training for all those who become involved as volunteers or as subprofessional or technical personnel in the fields that "teach, heal, serve or nurture."

Recruits and students.—The caliber of the person recruited to social work or social welfare remains the single most important element in our manpower situation. We are desperate for personnel because the nation has decided to solve the toughest of social and human problems, the problems that get in the way of decent human relations and satisfactory social functioning. Tasks can be sorted out, new patterns of intervention can be explored (the indigenous worker with the ghetto client, the social policy maker with community leaders), and a series of career lines can be charted. In the end, however, the intense, people-centered nature of most if not all of the functions to be performed in social welfare requires a degree of sensitivity, intelligence, and idealism that makes jobs in our field not everyone's "cup of tea." And we should not act as though they were.

There is nothing more shattering than to read in the newspapers such comments as one made in New York City by protesting welfare recipients. In describing their difficulties with the Welfare Department, they complained most bitterly to Commissioner Mitchell Ginsberg of the *inhumanity* of their "social workers." We may disclaim responsibility for persons called "social workers" who are not so qualified by professional education but we cannot escape involvement in the criticism and the reasons for it. When the bell tolls, it does indeed toll for us if, in our eagerness to promote training programs or to fill vacancies, we accept anyone who comes along. Intelligence and a strong feeling of common humanity with those who are served should remain an absolute guiding principle in the selection of recruits to the field, regardless of the dimensions or the pressures of the manpower problem.

It is possible that the principle of upward movement from social welfare employment into professional social work practice through qualifying graduate education may need to be abandoned as we work on career lines with differential use and training of personnel. This possibility has not yet been squarely faced by the social work profession, and I fear that the problems inherent in such a decision, particularly as they relate to the junior colleges and the two-year community colleges, may prove more troublesome than we had anticipated. As an occupational group we are committed, in theory and practice, to the idea of wide-open opportunity through upward mobility.

The Gardner model gives us a clue, but not an answer, to the handling of this problem. When he foresees that the social work education center of the 1990s will be the "hospitable center and intellectual home for all of the great array of occupations . . . that make up the field of social welfare broadly conceived," he is putting social work in the same relationship to still undesignated occupations as medicine now stands in relation to nursing and a host of semiprofessional and technical occupations in the health field. How we will structure the parasocial work occupations and how we will recruit and train for them are questions that remain to be answered. If we look for answers within the context of long-

range planning, we may not discover a magic formula but we should be able to avoid the trap and consequences of expedient responses to the immediate problem.

A last word on recruits and students is the reminder that the students we recruit now will be the architects, builders, and faculty members of that social work education center of the 1990s. They will need to be well exposed as undergraduates to the best that universities can offer in the social and behavioral sciences. As graduates they must become imbued with the values and knowledge and expert in the theory and practice of social work so that they will contribute out of a deep understanding and a thorough grasp of the role, purpose, and potential of the social work profession today and twenty-five years from today.

Faculty development.—The school of social work of the future, in Gardner's vision, will generate knowledge and help to apply it. It will unify services to people through fusing the worlds of research, teaching, and community service.

Faint stirrings toward this goal are discernible as schools establish research centers and move in the direction, as some now are, of developing demonstration service centers, or centers for research, training, and continuing education. The need emerges more sharply than ever before for faculty gifted as teachers, expert in practice, scholarly in research, and deft in relating to the three worlds in which increasingly they will function—the world of the university, the world of practice and community, and the world of interprofessional communication and cooperation.

Present doctoral programs are not yet adequate to the task of preparing the faculty needed for the social work education center of the 1990s. The relationship of social work education to the social and behavioral sciences in most of the schools with doctoral programs is still ill-defined; the production and testing of new knowledge in practice remains a hope for the future rather than a reality in the present; and interprofessional communication is not well-developed. But the germ of future achievement is there, and as we develop faculty to staff new graduate and undergraduate programs in order to meet immediate manpower needs, we shall

undoubtedly deepen the relationships and uncover the talent that will blossom in the teaching, research, and service environment of the new schools of 1990.

Some curriculum choices.—Just as the faculties for the 1990s are now in the making, so also are the curricula. Obviously, the content and even the general objectives must remain shrouded in the mystery of things to come. Yet, it is of the utmost importance to be constantly aware that the decisions we make today on curriculum development at all levels of education for social work will have a decided impact on what may or may not emerge twenty-five years from now.

The Gardner model puts special stress on close ties between the school of social work and the behavioral and social sciences and among the professional school, the basic disciplines, and the world of practice. The professional school and the social agencies would thus become joined with the basic scientific and scholarly fields in a new configuration for teaching, research, service, and continuing innovation.

The case for an organic relationship between the professional school of social work and the social and behavioral science fields has been made before, notably by Werner Boehm and Herbert Bisno.[4] In fact, if the structural recommendations for professional education had not been so thoroughly disliked, thus bringing the Council's whole curriculum study into mild and temporary disrepute, we would now be well started on the way to the kind of continuity and relationship envisaged by Gardner for social work and the social and behavioral sciences. This is not to say that the models are the same, but many of the ideas would lead in the same general direction.

The choices in the area of undergraduate education are particularly significant at this time. The Council on Social Work Education, in responsible and responsive action to meet manpower needs, is encouraging rapid development of social welfare concen-

[4] Werner W. Boehm, *Objectives of the Social Work Curriculum of the Future,* and Herbert Bisno, *The Place of the Undergraduate Curriculum in Social Work Education,* The Comprehensive Report of the Curriculum Study, Vols. I and II (New York: Council on Social Work Education, 1959).

trations within liberal education. The pressure is strong and the temptation great to vocationalize educational offerings at the undergraduate level in order to move bachelor degree graduates more quickly, more directly, and, presumably, more efficiently into social welfare employment. The Council and many of its member undergraduate departments have resisted this temptation because of the belief that all career lines, whether technical, subprofessional, or professional, must rest upon a strong educational base in the behavioral and social sciences and humanities.

The Gardner model supports this view, but pushes it further by suggesting that all the helping and service professions have common educational roots that must be identified and nourished. Is it conceivable that there could be a composite program at the undergraduate level for the various categories of subprofessional and technical personnel in health, education, and welfare? The walls that rise between the professions and between academic disciplines are forbiddingly high. Yet, there are signs that the walls may be coming down. The 1965 White House Conference on Health paved the way for new serious discussion of cooperative educational ventures in the health fields. The advantages in a composite program and common manpower pool for the fields of health, education, and welfare at the undergraduate level are self-evident and highly attractive. Whether social work could play a significant role in producing the educational hybrid and whether social welfare would get its fair share of the product are questions that only experience could answer.

As a professional group we have been much too occupied—and rightly so at this stage in our history—in forging our own distinctive educational program at the graduate level and in finding a recognized place of our own within the university structure where we can invite or welcome interdisciplinary and interprofessional educational planning. This is a task for the future and one that would engage us deeply up and down the educational ladder from the very beginnings of undergraduate study through doctoral and postdoctoral programs. John Gardner suggests that we should become involved even at the level of high school education, but with only twenty-five years to become a new and powerful educational

force in health, education, and welfare, I suggest that we leave the high school to others.

Twenty-five years seems a long time, but it may not be long enough to achieve the goals embodied in the Gardner vision of the social work education center of the 1990s. The peaks do indeed lie ahead of us. Enormous resources will be required—and I am convinced they will be forthcoming—if we start the hard upward climb. A dialogue without end must be initiated now within the profession, within our universities, and in our communities, to spread the word that social work education is entering a new era and to command support for ambitious new goals—goals that will embrace: responsibility for education and training to meet the full range of social work manpower needs; responsibility to match all considerations of quantity with the highest quality of learning; responsibility to work toward new alignments among schools of social work, social agencies, the behavioral and social science fields, and allied professions, with innovations leading to continuous renewal of the field of practice and educational arrangements for it.

The choices that we make today will determine whether we reach the summit twenty-five years from now. And even if we fail, we will still be better off for having made crucial manpower decisions within the context of desirable long-range goals and a total plan for their achievement. This, indeed, is where we should have started yesterday. This is where we must begin tomorrow.

Family Therapy for Delinquent Children from the Ghettos

by CHARLES H. KING

THE FAMILY, THE PRIMARY SOURCE of social and personality pathology, is also the fundamental source of health, especially for young children. The boys at Wiltwyck School for Boys range in age, at intake, from seven to ten and a half years. They are still youngsters, most of them under fourteen, when they return to their homes and still dependent upon their families for care and guidance. The family is as crucial then to their future development as it was in the critical years from birth to the age of trouble. Residential treatment agencies have long recognized this fact; few, if any, have faced up to the necessity of involving the families of excessively deprived delinquent children in any intensive program of rehabilitation.

The reasons for this omission are many and varied, but whether the agencies are defeatist in their attempts (as indicated by labeling the families as "poorly motivated," "multiproblem," "high-risk") or benign (with their aggressive casework and reaching out), the end result is the same: agency energy is invested against chronic resistance with very poor results, and finally abandonment of the effort.

Corrective measures for the delinquent child are prescribed by the courts. They are considered by the child's parents as intrusive, not helpful; as validations of their own massive helplessness, of which the demonstrated inability to control their children is but one small facet. This is true even when the parents themselves initiate court action. Most of these families have been on relief

rolls for generations. Major decisions about themselves, about their children, about their basic existence—where to live; how much rent to pay; what to eat; how many garments and what kind of clothes to wear; whether or not to have a telephone and television—rest outside their control except as they can subvert the welfare rules and maneuver around the law.

One of the most important elements in understanding such families and the way in which they rear their children, and particularly the lack of socialization of their children, is the fact that there is no privacy in their lives. They are open to all kinds of intervention in regard to survival or behavior, whether their own or their children's. This creates an atmosphere in which there is no hope; there is no self-planning, and consequently there can be no future. They live in a here and now which is filled with momentary, often stolen, pleasure, with chronic despair.

Faced with an existence in which survival is the theme of life—a capricious theme since it depends upon others (those hostile "others," the Department of Welfare, social agencies, the courts) —these families develop a family style or pattern of adjustment lacking in consistent parental authority, in guidance or direction from adults. Past the age of five, roughly, the children are left to discover, cope with, and master their environment as best they can.

The families of delinquents typically consist of a membership group of individuals rather than an intimate body of people who look to an adult head for discipline and direction. As a result, the children look to themselves, to their siblings, and to their peers for guidance, for clues as to what the world is like. This becomes a vicious, fragmenting search, especially since all the pangs and throes of sibling rivalry exist in these families as intensely as in any other family. It is excruciatingly difficult to rival a sibling when he is a poorly defined, but frequently used, parent surrogate and one is dependent upon him. The turning of these children to each other creates a sibling subculture and a parallel gang culture outside the home which is delinquent in character, adult-defying in nature, sporadic and not goal-motivated in action, and, not infrequently, senselessly violent. These are primitive, unprotected chil-

dren who see the outside world either as a preying world or as prey.

The tremendous pressures of social ostracism, of discrimination, of poverty—all of which are critical determinants in the maladaptive adjustment of these children—cannot be elaborated within the scope of this discussion. These factors are basic, however, and heavily causal in the shaping of the parents' lives.

The principal factor contributing to delinquency, then, seems to be the abdication of parental authority and the almost complete dissociation of these families from the prevailing social structure. Internally, this abdication results in a fantastic lack of differentiation amongst the children, which the realities of large families, overcrowded apartments, and lack of privacy aggravate. There is even a language of undifferentiation. Children are referred to as "him," "her," "somebody," "they," "people," and the powerful word "nothin'" dominates the communication of the children with their families—all leading to a lack of personal identification. Furthermore, in daily living the parents do not relate to their children according to their age and seldom according to their sex.

In family therapy sessions we have seen a harassed mother slap the child nearest her because she was angry with a child she could not reach, or shove a lollipop into the hand of a fifteen-year-old—again because of proximity—when it was the five-year-old who was crying for it.

One mother spoke of her large family, with many children yelling at once, as though she were trying angrily and helplessly to relate to a noisy orchestra. She could not place any one single instrument, that is, one child.

The fact that these families do not discuss teachers, policemen, grocers, or anyone else, in terms of their role sends the children into the world seriously lacking in common knowledge. Since they have not been taught, or required, to think, even the apparatus of cognition may be faulty. They simply do not know what to expect, what is expected of them, who they are, or who other people are in relation to them.

We in the schools, in the courts, in residential treatment centers, and in all intervention facilities are coping with children who

speak in a language of their own and who are responsive to inner stereotyped cues (all adults are hostile, dangerous, or patsies, and that's it!); children who are reactors; children who have a poor sense of time and space and no sense of causation; children who are spontaneously defiant and offer a constant threat of violence; and families which adamantly refuse to assume responsibility for their children or even to admit that trouble or problems exist except occasionally, and then in the most abject and servile but resisting manner.

Above all else, these families experience only a validation of failure when placement must be found for a child or an agency makes an exhaustive investigation in order that they may receive relief payments, especially when the interrogation takes place in the presence of the children.

What kind of remedial, rehabilitative, and therapeutic help is available to these families through family therapy? What kind of constructive impact can family therapy have upon them?

Floyd Patterson House is operated by Wiltwyck School as a halfway house for family therapy. Most of the boys come to Patterson House from the main Wiltwyck residence on their way back into the community. They are returned from Patterson House to their own homes. A few boys are taken into Patterson House directly from the community. These are boys we feel can remain in the city but not in their own homes.

Since the same objectives and careful programing are found in all of Wiltwyck's facilities, the particular advantage of Patterson House is its location in the city and its accessibility to the families of the boys, who live there from six to eighteen months. In the staff's handling of the boys, many of the skills expected of parents are put to use. Patterson House is systems-oriented. This means that all of its personnel, from director to janitor, are part of a planned system of adults who treat these children at all times, regardless of provocation, with firmness, consistency, acceptance, and guidance. If one member of the house should fail to meet this challenge, others fill the breach to protect the consistency of approach. An intensive and highly selective in-service training program assures us of a staff which will not respond with anger, rejec-

tion, seduction, or alienation to the incessant provocation of the children. In training sessions, flaws in technique are openly discussed and disagreements frankly aired so that high morale and open communication are maximized and the devastating possibility that children will play adult against adult is minimized.

The milieu, therefore, duplicates the sound, healthy environment of a good family, although it is quite clear to staff, children, and parents that Patterson House is a training facility where one goes to learn; it is not a substitute home even though children do stay there from six months to a year and a half.

Since the pioneering days of Dr. Salvador Minuchin, Charles H. King, Dr. Edgar H. Auerswald, and Clara Rabinowitz, who began family therapy at Wiltwyck, our techniques have greatly expanded; methods have changed and approaches have been modified, largely in the work of Dr. Steve E. Fochios, former Chief of Psychiatric Services at Patterson House, and Saul Pavlin, Director of Patterson House. Nevertheless, the objectives and fundamental approach have remained the same because the dynamics and characteristics of our families are consistent. Traditional techniques of group and individual therapy—the give-and-take of verbal interaction and interpretation—were not by themselves appropriate to our family therapy. Our intervention in the family system has to be action-oriented, demonstrative. We have to enter and leave the family system, making an impact upon its operations. We have to educate, to teach, and to train the family both in its sibling and its parental roles; then we are faced with all the vicissitudes of personality and role interaction and their influences on the rearing of healthy children while maintaining some balance among other roles, such as husband and wife, older sibling and younger sibling.

A family system is a regular, consistent way in which the members relate to each other, talk to each other, cope with each other, and try to solve mutual problems. For example, in many families, when the mother is disturbed, the rest of the family becomes extremely protective, denying the illness and organizing its members to avoid distressing her. The father and children will learn how to operate as though the mother's sick distortions were real. In such a family, the children will carry out the mother's orders and support

her stories, even when they may be lies or fantasies. What is more important is the subtle agreement to do nothing to ruffle the mother. Therapists exposed to this type of family will find themselves walking on eggs with the mother, hesitant and also protective, frequently at the expense of gaining true knowledge and gathering facts.

The most challenging test to the therapist is the entering into, and freeing himself from, the family system. So much rides on the delicate balance of the therapist, who must maintain his own will and identity and help the family follow him productively through his various roles. The "suction of the system," as Dr. Fochios has termed it, is tremendous. One can easily become a part of it.

For example, we are acutely sensitive to the kind of style in which our families live, to the "integrating theme," in Dr. Auerswald's words. In one particular family, consisting of five boys ranging in age from nine to eighteen, a highly intelligent mother (high school graduate), and an extremely bright father who was in and out of jail for fraud, the family theme was one of threats, stealing, and seduction. All control in the family was phrased as either a direct or a subtle threat or exercised through seduction by the mother. The family was a jungle of strife, with small oases of control when a threat was effective. The boys threatened each other, and the mother with interposing the father's authority when he was out of prison or about to be released. They stole defiantly from each other, from their mother, from the neighborhood, either lying about it or openly admitting that this was the only way to maintain equality in the family and to see that no one got more than his share. The mother, though deeply religious, tried to overlook the thefts; to admit them would be to admit her inability to stop them. The family felt itself to be a family only when it was under some stress resulting from theft or acting-out behavior. When these stresses were missing even momentarily, the children were restless, anxious, floating, as though they could not bear to be relaxed or quiet. They had to be doing something which would bring about the mother's threats or her seductive appeals for them to stop.

The mother was a charming, highly seductive woman who com-

bined those deadly female qualities of maternal appeal ("I can mother everyone") and sex appeal ("I am as yet an unfulfilled, unawakened maiden"). This presented its own special problems for husband, sons, and the male therapists.

After many intensive family sessions with this mother and her sons—the father was present only occasionally since he could not remain out of jail and when he was out, lived with another woman—the following incident occurred. Involving more than technique or experience, it illustrates the relentless suction of the family system. The mother and the boys had been arriving at the time scheduled for their sessions at Patterson House. Problems of "family noise" were well under control, and the general improvement in the appearance of the boys was outstanding.

On Thursday, John arrived late, sloppily dressed; apparently he was aware that this was a breach in his progress. He began immediately to attack one of his brothers verbally. The brother jumped up, threatened to bash his face in. The mother sat quietly. John finally said to his brother, "Go --- yourself." At this point the therapist turned to John, making no reference to the budding fight, and said, "Hi, you didn't say hello to me." John apologized profusely; the tension eased immediately. Facing the threat of violence, our therapist had moved in as pacifier, deflecting the conflict, and because the family had a powerful investment in his care, his interest, this move quieted them. They gave up the fight with obvious relief. But the therapist himself, in an after-analysis discussion, pointed out that the core problem remained, that of leading these boys to change the pattern of violence and conflict among themselves and to elicit full family cooperation in this endeavor. This session had done little to further that objective because the therapist too, in the interest of sanity and order, had taken part in the family's old way of operating. He was the seductive pacifier but he only postponed conflict.

The establishment of order in a family is of critical importance, however, and becomes for us the first order of business. When children are fidgety, noisy, inattentive, and the parents listless, detached, nothing we try to do is felt, registered, or meaningful. We can make no impact while this situation continues. We strive to

take hold of the family ourselves and to establish order through promoting parental effort. The following piece of interaction quoted from a family therapy report illustrates this:

> A dominant tone of the meeting was the boisterousness, the abusiveness, the constant interruptions, the negativism, the defiance of the three children toward the therapist and the co-therapist. The mother's response was generally that of apathy, listlessness, and helplessness. However, on several occasions she did move in to control her children in a way that supplemented the control that the therapist and co-therapist were attempting to apply to the children. The children did not respond directly to the therapist's request, but when the mother echoed what the therapist said, they did respond on several occasions.

To oversimplify, we have to teach our clients as well as provide therapy. In the early exploratory days, we set as the initial task of our family therapy the creation of a family, a sense of people belonging together under the direction of an adult with a clear role, and division between adults and children. We made this division along the lines of discipline and control as well as of teaching and guidance. Mothers, or both parents, would assemble the family in our office at a given time for us to talk with them. Parents could give whatever explanation they wanted to their children, but the "simple" task was to get all the children to come together for the meeting. Thus, in the most primitive, easy fashion, we would "fix" a family in space and time, and under parental control. In order to facilitate matters, we offered to pay carfare and baby-sitting fees so that the parents' sole recourse, if they could not bring a particular child, was to admit their inability to exercise parental authority. We seized upon such inability as a primary problem, explaining that lack of control of one child meant trouble for all the family. We made home visits when necessary. Our goal was to establish a family setting in which there was at least tacit recognition of a parental head and siblings, with the parents able to command the children's presence anywhere. We enjoyed both an early and a continued success in getting families to accomplish this simple task.

Our next general problem was what Dr. Minuchin characterizes as "family noise." The "noise" was often terrific. Attempts to converse with any one family member, parents included, were met

with loud and indiscriminate talking, playing among the children, reading of comic books. Moreover, in some instances the children actually fell asleep during the session. Sleep was considered by the therapists as "noise" because of its distracting effect. At times there was loud snoring which therapists struggled with as the ultimate in contempt.

We began to control the "noise" by exerting our own authority, supporting the parents' attempt to quiet the children, wake them up, emphasizing and demonstrating that they could be recognized and heard, and attended to as individuals only when they permitted each other to talk without interruption and distraction. Otherwise all we heard was noise, and we could never tell who was speaking; who wanted what.

Our model in our pioneering sessions was that of a ninety-minute, two-therapist, three-phase interview. Our rationale was that two therapists were essential to keep the dynamics of faulty interaction under control. While one therapist was talking with a family member, the second one would observe the verbal and nonverbal responses of the other members and bring these into the discussion. The two therapists also acted as correctives for each other. Often during the session they would and did disagree, thus demonstrating the possibility of disagreement without the disaster of fighting and hurt feelings.

The presence of two therapists also permitted us to work with the family along its natural organizational lines of parents and siblings. During the course of the hour and a half we would first see the family as a unit. Then, usually, one therapist would take the parents aside and one the children, to see what would come out in discussions with parents free of children and children free of parents. Often we found that children behaved entirely differently at such times. For the most part, they were freer in behavior, more volatile, more open in their criticism of each other and their parents, and more clearly expressing a yearning for something—attention, control, guidance—while the adults sometimes showed their desire to be released from the role of parent. We found, too, that the parental perception of the children's roles differed from that of the child and his siblings. For example, a child assigned the

role of "mother," to control or report the behavior of his siblings, was often as confused and miserable as his siblings despite the parents' notion that this was a constructive arrangement. Mother frequently rationalized trouble on this score as the obstinacy or rebellion of whichever child was causing difficulty at a given moment.

In the last section of the three-stage interview we reassembled the family and brought out pertinent disclosures of what took place in the separate sessions. As our experience grew, we came to see that certain segments of the family, such as dyads (a mother and her son; two sons; a son and a daughter), were usually more prominent when the family was split into two therapy groups, if indeed such a tactic was indicated; sometimes we kept the family together throughout the one and a half hours.

What must be understood, however, is that in our family therapy we worked for role clarity—what a mother does; how a five-year-old behaves; what siblings do; what husband and wife do. Our therapy was geared to rehabilitating a family. Our techniques were used to build a healthier family, hence we tried to place each family member in the family as a part of that family. Our interpretations were more along the lines of clearing communication among family members and opening up support for the growth and development of each member in the family—and eventually out of the family—than of resolving individual problems, though we were prepared to offer individual help with special support when indicated. Through role clarification and healthy child-rearing practices we focused upon problems of identity, constantly stressing who they were, where they were, for what purpose they were here, who was helping and why.

Out of this concentration, Dr. Fochios became sharply aware of how vitally necessary it is in rehabilitation to help parents and children to know when they have made progress; to draw progress charts for them in behavior, in understanding, and in effectiveness. Consequently, Dr. Fochios and Mr. Pavlin developed a method by which parents who were still in the learning process could observe, via a one-way-mirror, how more effective parents handled their families. These parents watched other parents handle their children in the family session. The parents who were

being watched knew that they were being watched and took great pride in their own increasing effectiveness and in being able to teach others how to be mothers and fathers. The participation was a full one in that parents could talk with other parents after the session or actually go into the session itself and become part of what was going on as observers, as mothers, learning to be more effective parents. With the help of therapists who were also observing these families, the learning experience was maximized; for the parents could see that our objectives could be realized.

Family therapy at Floyd Patterson House and throughout the Wiltwyck system is growing and developing. We believe that the weekly meetings in our office have successfully kept families in contact; for they set for the parents specific tasks (such as the disciplining of their children), help them to achieve these tasks, and above all else show these parents that something is expected of them, thereby breaking through their resistance and breaching the wall of isolation and disaffection.

With us, family therapy does not take place in a vacuum of therapeutic procedures unrelated to the outside world. Training parents and children to cope with the community, knowing that they have us as a resource both to open doors for them and to support their own efforts, is a vital part of rehabilitation. Schools are of especially critical importance, and we involve them directly in our programing. Principals, guidance counselors, and teachers observe and take part in family sessions, clinical conferences, and Patterson House staff conferences. Indeed, our techniques of working with these families, our understanding of them, and our education-for-life approach are recognized and used by other agencies, particularly the school system; one special educational program for deprived and disturbed youngsters sends its teachers to Patterson House to study our methods as part of their basic training.

All we do for these children and their families is very much related, as it must be, to the communities from which they come. We are their advocates and their teachers as they learn how to cope more effectively and how to use community support to the fullest.

To paraphrase Dr. Richard Rabkin, present chief of Psychiatric

Services, who summed up our family therapy program at the 1966 annual meeting of the American Orthopsychiatric Association: the goal in therapy is to create different horizons for the parents of these children. Currently, there seem to them to be but two alternatives: to punish their children to no avail, or to try to escape from parental responsibilities completely:

> A third possibility, the possibility of a balanced, mutually satisfying, tender relationship, is initially as odd and inconceivable as family therapy itself. Pain becomes a reward and satisfaction a punishment because of a third factor, what might be called "family consciousness," "social integrity," "security," and so forth. For a delinquent child pain is endured to establish contact and satisfactions are hollow when family feeling is absent.

We want to give these children and their families that "family feeling." Only then can we have a real impact which will promote growth and development and sustain progress in their children who have benefited from constructive intervention.

New Insights into Ego Assessment

by FRIEDERICKA MAYERS

LET US TAKE "ego assessment" to mean the way in which we estimate how much mastery or control a person has achieved over himself in his relationships with his environment at any given time. Our purpose will be to examine the usefulness of ego assessment as a tool. How well does it help us to sharpen our powers of observation, to partialize and organize the complexities we have to deal with in practice? How well does it help us to integrate and test our ideas and theories in research?

In helping untrained and inexperienced practitioners work with clients whose ego's balance is precarious, we could use an accurate, simple, dependable measure of the ego's rate of decompensation; a way to assess the disintegration of the ego's regulatory functions; an indicator of the brittleness of defenses; a clear sign of precarious integration. As we come to know more about the ego, we acquire increasing respect for its complexity and we want to communicate that respect to others. For this, the knowledge gained from ego assessment may be useful. Working with the "deprived" who have our sympathy, the "deviant" who arouse our prejudice, and the "hard to reach" who reject and frustrate our efforts, we need to be objective and consistent. Ego assessment may help us to resist the tendency toward initial overzealousness with its subsequent premature disillusionment which often leaves people worse off instead of better.

Ego assessment, even in its present imprecise form, is already advocated by some clinical practitioners. Bellak and Small, for instance recommend the use of ego assessment in their recent book, which emphasizes the crisis-oriented approach. They present a

general descriptive guide to ego assessment under such topical headings as, "adaptation to reality," "reality testing," "sense of reality," "regulation and control of drives," "object relations," "thought processes," "defensive functions," "autonomous functions," and "synthetic functions." They point out the importance —certainly not limited to crisis-oriented casework—of identifying the "intact residue," or healthy portion of the ego with which one works. They say that a primary value of an assessment of ego functions is its capacity to prevent oversimplification, or the reliance upon a unitary approach.[1] It is clear that as ego assessment becomes more precise it becomes more and more useful as a guide in choosing among alternative interventions in treatment. Until recently, choice of treatment even among the most general modalities of individual, joint family, and group treatment has been made largely according to what has been called the principle of the "drunkard's search." As the story goes, a drunkard was searching under a street lamp for his house key although he had dropped it some distance away. When asked why he didn't look where he dropped it, he said, "It's lighter here."

The point is, of course, obvious. When we get overly involved in developing a new service, treatment, or environmental opportunity, we sometimes lose perspective and think this is the light under which we should look for everything. If we want to be more discriminating in trying different ways of working with different kinds of people, ego assessment is a way of identifying the differences that matter. As Bellak and Small point out, the old diagnostic categories are neither sufficiently discriminating nor closely enough related to treatment alternatives to serve as guides in practice. It may be that with increasing knowledge and skill, ego assessment will provide more meaningful ways of relating diagnosis to treatment.

For example, under the diagnostic label of "schizophrenic" we may categorize individuals with or without difficulties in object relationships and with or without disturbances in thinking. According to Bellak and Small:

[1] Leopold Bellak and Leonard Small, *Emergency Psychotherapy and Brief Psychotherapy* (New York: Grune & Stratton, 1965), p. 68.

The schizophrenic who primarily suffers from a thought disturbance in that he has not yet acquired the structure of time and space may never benefit from any amount of good relationship or from the most loving mother or mother-substitute in the world. What he requires is the development of adequate secondary-thought processes.[2]

Although we look forward to some day being able to use ego assessment in order to select more appropriately among treatment alternatives, we must also recognize that we are a long way from doing this today. Overgeneralization, lack of clarity, and a plethora of untested assumptions frequently slip in now under the aegis of ego psychology. For example, there is much we have to learn about the ego before we can readily make use in our practice of such general statements as the following:

The problems in treating the defensive functions are very similar to those encountered in the treatment of impulse control. The inquiry must be directed toward assessing whether there is too much or too little of the defense. Mediate catharsis or drive restraint may be necessary in different cases. Secondary measures involving manipulation of the environment in order to decrease the pressure of stimuli are often essential.[3]

If ego assessment seems formidable at first, it becomes more so for most of us when we are faced with such generalities. This is why concept clarification is so frequently the first step in research. And this is why I have chosen to discuss first some research which makes a contribution to clarifying what we mean by "ego strength" and "maladaptive" or "adaptive" defenses. As we get a clearer idea of what it is we are trying to assess and how these assessments are related to what we do or do not do in treatment, we may have a firmer base from which to improve our skills and economize our efforts.

Since the advantages of ego assessment depend on our having clear, accurate measures of the ego which are reasonably simple to apply by casework methods, we must ask how close we already are to having this kind of measure. A number of studies seem to be contributing to this refinement. One is a study done at the Psychoanalytic Clinic for Training and Research at Columbia University

[2] *Ibid.*, p. 69. [3] *Ibid.*, p. 72.

by Aaron Karush, B. Ruth Easser, Arnold Cooper, and Bluma Swerdloff on "The Evaluation of Ego Strength: a profile of Adaptive Balance." Dr. Swerdloff was the social worker on the research team. The purpose of the research was to see whether the concept of ego strength could be sufficiently clarified, defined in standard clinical terms, and reliably scaled so that comparisons could be made among different patients.

Social workers have long used the concept of "evaluating ego strengths," and all of us probably have our own ideas of how difficult it is to be precise about just what ego strength consists of and how to assess it accurately. Eminent psychoanalytic theoreticians have had their own difficulties with the concept, as this study points out. In 1938 a symposium on ego strength at the fifteenth International Psychoanalytical Congress first outlined some of these difficulties; a panel discussion on ego distortion at the twentieth Congress in 1957 was still not able to resolve them.

This is the difficulty, some say the impossibility, of assessing ego strength without taking into account such other factors as the strength of the individual's impulses, the amount of regression, the relation to environmental factors past and present, and object relations in particular. As the study by Karush *et al.* points out, Glover, Hartmann, and others have emphasized that ego strength can best be assessed by assuming it to be the adaptive balance of the ego as indicated by its relations to its environment.

To translate this concept of ego strength into assessments that could be made from clinical material, the authors assumed that an assessment of ego strength could be made from a graph of the patient's ratings on nine scales or measures of adaptive balance. To do this, ordinary clinical material was used of the kind with which we are all familiar: the behavior and self-presentation of the patient in the initial interviews and what he told about his primary family relationships, his sexual behavior, marriage, parenthood, work, and the social and cultural aspects of his life.

Examples from this kind of clinical material were rated comparatively as they were judged to show more or less adaptation in nine areas. Adaptive balance was judged from evidence that there was neither too much nor too little of the following general char-

acteristics: (1) dependency in self-object relationships; (2) genital satisfaction or frustration; (3) other forms of satisfaction, such as pleasure or frustration out of life in general; (4) emotionality or affective balance; (5) stress reactions or emergency emotional balance; (6) the amount of defenses; (7) guilt; (8) pathology; (9) social interaction.

How to assess the amount or degree of a client's reaction to stress as expressed in hostility or rage is, of course, a familiar problem to social workers. Here is an example of how it was done in this research. A rating of plus 1 was given to expressions of rage which could be described as follows:

Rage is greater in intensity and/or experienced more frequently than is appropriate in situations commonly recognized as threatening, provocative, or frustrating and which would ordinarily arouse some anger and/or aggressive act. Rage may be experienced as angry feelings or thoughts and expressed as short-lived irritability, sullenness or sulkiness. Rage is limited in duration and can be consciously controlled by suppression. The impairment of functioning is of mild intensity.[4]

Skipping the description of the amount of rage which was rated plus 2 and 3, the following describes the kind of behavior which was rated plus 4:

Rage is commonly elicited by the ordinary demands of life and is a characteristic response to stress. Aggressive, paranoid ideas frequently interfere with interpersonal relations. General hostility toward the environment is a dominant feature of thought and behavior. Suppression and displacement are seldom able to help control the rage which may lead to physical assaultiveness for real and fancied grievances. The degree of impairment of functioning is usually of severe intensity.[5]

How much adequate functioning is impaired by such reactions to stress or other disturbances of homeostatic balance must be assessed, of course. The way it is done in this research is to rate impairment of functioning as follows:

Mild: Pleasure is maintained with brief periods of diminution; anxiety, rage, or guilt have no disorganizing impact upon the basic needs for food, sleep, sex. Function in the various areas of behavior is not affected or is temporarily impaired in one or two areas.

[4] Aaron Karush, *et al.*, "The Evaluation of Ego Strength. I: a Profile of Adaptive Balance," *Journal of Nervous and Mental Diseases*, 139, No. 4 (1964), 338.

[5] *Ibid.*, p. 339.

Moderate: Pleasure is reduced with periodic recovery of the capacity for gratification; anxiety, rage or guilt intermittently impair appetite, disturb sleep and reduce the sexual drive; function in some areas of behavior is definitely impaired but with periods of remission.

Severe: Pleasure is markedly reduced without remission; basic needs for food, sleep and sex are chronically disturbed; there is inability to be distracted from the anxiety, rage or guilt; function in most or all areas of behavior remains markedly impaired.[6]

From these examples we may begin to get some idea as to whether this kind of ego assessment would be of any use in practice. We may ask, for instance, whether this way of assessing the ego's regulation and control of what we might call "frustration aggression under stress" would be helpful to a relatively inexperienced worker; whether this assessment would indicate some fruitful areas for observation and exploration which might help in determining the necessity for immediate service or for some kind of careful handling; whether this assessment would indicate the client's level of toleration for a lengthy intake, joint family, or group session.

Another area where research and practice may share in a cooperative contribution is in the assessment of the defenses as related to choice of treatment alternatives. Several major research undertakings in the behavioral sciences have attempted clarification of the concept of the defenses by defining them in terms of behavioral indicators which can be dependably and objectively observed and measured. In addition, some connections have been investigated between defensive behavior and other factors, such as child-rearing attitudes and behaviors, sex, age, socioeconomic status, intelligence, moral development, and so forth. The importance of this kind of research to casework practice is, of course, that it provides a fund of knowledge which helps the worker link observations of a particular person in a particular situation to what is known or can be expected in a wider context.

Ego assessment in casework practice and research can provide a way of organizing or programing what we already know so that it is made readily usable either for individual practice or as a basis for research for the advancement and improvement of practice.

[6] *Ibid.*, p. 339.

Ego psychology may be thought of as a system for the storage and retrieval of information. In this sense the concept of the ego and its autonomous, defensive, coping, and integrative functions may be regarded as a device for information classification and retrieval and for putting certain items of information into different contexts or relationships with other items of information.

In practice, a kind of intuitive ego appraisal, learned through long experience, is used as a guide in choosing among alternative treatment interventions with information retrieval from the storehouse of memory. In other words, a particular aspect of ego functioning observed in the client before me reminds me of previous experiences in working with clients' functioning, and making allowances for the difference in circumstances, I plan how to proceed this time. Practice research follows a similar process but makes possible learning through not just one person's lifetime of experience but through the experiences of many. The varied contexts within which the individual worker may then draw upon the experiences of others makes possible a vast improvement of skill and understanding.

As an example, let us return to the assessment of the defenses which Bellak and Small mention in a very general way as being useful for the choice of treatment in clinical practice. This concept of the defenses puts us in touch not only with the experiences of psychoanalytically oriented theoreticians and practitioners, but also with the empirical research of behavioral scientists who have related this concept to those of socioeconomic class, the development of intelligence and moral values, child rearing, and others already mentioned.

In practice, there is considerable difference among workers as to whether they assess the defenses, what observable behavior they use as evidence of the different defenses, how they evaluate the evidence they see in connection with the other ego functions and the client's total situation, and how they use all this information helpfully on behalf of the client and not just as an intellectual exercise for school or diagnostic staffs. If one were to judge by what is recorded in case records, one might conclude that a listing of three or four defenses was the extent to which the concept was useful.

If that is all, one wonders why we bother with the concept at all. If, on the other hand, it has some usefulness to practice, what can be done to bring out that usefulness? It has been pointed out that the term "defense" has been indiscriminately used, that the number of defenses identified and labeled has increased beyond any practical usefulness, and that ambiguity has resulted from disagreement as to the essential characteristics of the defensive process itself.[7]

In casework practice the relationship of the defenses to the treatment process itself has not been developed much beyond the maxim that under ordinary circumstances one should neither attack nor play into the defenses unless one knows what one is doing and proceeds with caution. For the long-experienced worker, however, this maxim brings to mind a wealth of information that makes it possible in any individual case to get a rough idea of the important defenses that one had better not attack or play into. Nevertheless, it is usually very difficult to put this process into words either to record exactly what one is doing or to tell someone what it is better not to do and why.

One of the major issues in the theory of the defenses is, of course, whether the defensive process is essentially pathological or whether it may be a normal process also; whether the term covers only unconscious mechanisms or may be conceived of as including or being allied to conscious mechanisms that resemble the defenses. The difficulty is that the dividing lines are very vague between what is pathological and what is not, what is usually conscious and what is not. Even in individual instances this is somewhat difficult to tell, but when we begin to generalize over many instances we tend to get very fuzzy indeed.

Several research projects have tried to grapple with the question of differentiating maladaptive defenses from the adaptive, coping mechanisms, particularly in trying to understand what underlying relationship there might be between them. Three such studies by Haan and Kroeber have developed a model of ego functioning which assumes that the mechanisms of the ego can be thought of as

[7] Samuel J. Sperling, M.D., "On Denial and the Essential Nature of Defences," *International Journal of Psycho-Analysis*, XXXIX (1958), 25–38.

general functions of the ego which take on either defensive or coping attributes, depending on whether they are viewed as warding off internal or external danger or as trying to master it.[8] Defensive behavior, according to these authors, is rigid, pushed from the past, distorts the present situation, provides an undifferentiated response, assumes that disturbing emotions can be magically removed, and allows impulse gratification by subterfuge.

Coping behavior, on the other hand, involves choice and is, therefore, flexible and purposive; is pulled toward the future but also takes account of the needs of the present; is highly differentiated in response; selectively controls the experiencing of disturbing emotions; provides for impulse satisfaction in a socially acceptable and, therefore, in an open, ordered, and tempered way. The authors describe the psychological processes which seem to be basic to ten ego functions, each of which may be viewed from its defensive or adaptive aspect. The first five are primarily thought processes or cognitive controls and put one in touch with research in cognition. The rest are processes of regulating or channeling impulse and affect through which one is connected to the massive body of motivational research.

For example, Haan and Kroeber point out the importance of the process of cognitive discrimination through which ideas and feelings are distinguished from one another. This may be called "isolation" when it is used as a defense and "objectivity" when it is used to cope. Another important function is cognitive detachment or speculation, the capacity for freeing significant detail from its immediate context, of not being stimulus-bound. This may be called "intellectualization" when it is used as a defense and "creative intellectuality" when it is used to cope. Impulse diversion or canalization whereby the individual modifies or changes the object of an impulse may be called "displacement" when it is used as a

[8] Norma Haan, "The Relationship of Ego Functioning and Intelligence to Social Status and Social Mobility," *Journal of Abnormal and Social Psychology,* LIX (1964), 594–605; "Proposed Model of Ego Functioning: Coping and Defense Mechanism in Relationship to IQ Change," *Psychological Monograph: General and Applied,* LXXVII, No. 8 (1963), 1–23; Theodore Kroeber, "The Coping Functions of the Ego Mechanisms," in Robert W. White, ed., *The Study of Lives* (New York: Atherton Press, 1964), pp. 179–98.

defense, and "sublimation" when it is used to cope. Time reversal, the mental process whereby the individual can replay or recapture experience, is called "regression" when it is used as a defense and "regression in the service of the ego" when it is used to cope. Of course, any of these or the other six processes may provide a whole field of specialized study or only a few useful guidelines in practice, depending on how much one wishes to know. The point being made here is that these are useful concepts for keeping in touch with advancing knowledge in practice and research.

The usefulness of this kind of ego assessment model for casework practice is twofold. In the first place, it helps to discriminate areas of behavior or aspects of ego functioning for closer attention; secondly, it makes possible the putting into practice of accumulated knowledge in these important areas. For example, under the terms "displacement" and "sublimation" one can look up a wealth of information in the behavioral sciences and the practice arts. In the Haan and Kroeber studies, one can look at some of the relationships between these defensive and coping behaviors and IQ change, sex differences, social class, sex role typing, social status, and social mobility. For the individual practitioner faced with the problem of what to do in treatment or how to find the best possible individualized service it helps answer the question: Under what conditions does it make a difference what I do?

Another example of tools which are ready and waiting for the practitioner may be found in Prelinger and Zimet's *An Ego-psychological Approach to Character Assessment.* Here are seventy-eight five-point rating scales developed from the viewpoint of psychoanalytic ego psychology, with case material from interviews and projective tests. Of particular value are the authors' attempts to operationalize Erikson's psychosocial modalities, which have been somewhat difficult to use in research up to now. Instead of selecting a scale from one of these modalities, however, I have chosen as an example one called "body image":

1. The body is highly overvalued; there may be a conviction of its perfection and beauty; its enhancement and care are a major purpose in life

2. The body is considered important as a well-functioning and dependable tool or asset; there is satisfaction with the body

3. The body is considered all right and on the whole functioning appropriately; there is no great preoccupation with it

4. The body is disregarded or neglected; or it may be sensed as imperfect in some respects, is disliked, devaluated, and not considered an asset

5. The body is felt to be strange, possessed by uncontrollable and/or malicious forces; it may be felt to be malfunctioning or disintegrating or to be diseased; bizarre body preoccupations may appear [9]

It is clear from this scale, of course, that for some children to have mirrors placed around a room—as was reportedly done in a kindergarten room by untrained workers who wished to correct the negative self-image of their small Negro charges—might be a very gratifying experience, but for others it would be a terrifying and, perhaps, a disintegrating one.

As is probably also clear, the applicability of the Prelinger and Zimet study for social work practice would for the most part be to generate ideas for workshops and in-service training. Considerable concept clarification and definition of terms would be necessary before these scales would be of immediate use in practice. The selection of illustrative case material from records or current interviews would forge a tool—custom-made to the specific needs of the workers involved—for digging out answers to some of their practical problems, such as, perhaps: Can we identify by our ego assessments the clients who will drop out of treatment? Or the ones we will later rate as treatment successes? Or the ones we believe do better in joint family treatment than in individual treatment? Or the ones we should have referred elsewhere in the first place? Or the ones for whom we want to work out more effective treatment methods?

In my own study,[10] the question I wanted to answer was

[9] Ernest Prelinger and Carl N. Zimet, *An Ego-psychological Approach to Character Assessment* (New York: Free Press of Glencoe, 1964), p. 63.

[10] Friedericka Mayers, "Assessments at Intake Related to Outcome at Case Closing for Emotionally Disturbed Children Served in a Therapeutic Nursery" (unpublished doctoral dissertation, University of Chicago, School of Social Service Administration, 1965).

whether there was any relationship between an ego assessment made on the basis of the material available in the case records from the intake study period and diagnostic staff conference and the outcome judged from the closing summary of the case. I worked with the case records of seventy-four disturbed preschool children and their families who received service from the Virginia Frank Child Development Center of the Chicago Jewish Family and Community Service.

I looked for material in the intake records and diagnostic staff minutes to rate the child's ego and the parental and family functioning on fifty-six scales. Those pertaining to the child's ego functioning were energy utilization, perception, motor coordination, speech development, intelligence, expression and control of fantasy, expression and control of emotion, integrative equilibrium or disequilibrium, chronicity of disequilibrium, frustration tolerance, attention span, and the nature of the defense mechanisms.

As would be expected, there were statistically significant differences in outcome between children rated at intake as normal in the utilization of energy and those rated as disturbed in this respect. Children who were assessed at intake as being interested, alert, animated or active, were twice as likely to be in the good outcome group at closing as in the poor. Children assessed as being either apathetic and passive or restless and hyperactive were twice as likely to be in the poor outcome group as in the good.

Frustration tolerance and attention span were the two ego functions for which there were the greatest differences in outcome. Only one child rated as normal in frustration tolerance at intake was in the poor outcome group at closing. The results were very similar for attention span. Thus, the capacity to withstand or contain tension, to wait, to put up with not having needs and wants satisfied immediately and the capacity to sustain interest in people and things and thus to obtain increasing gratification from them, were found to be the most differentiating diagnostic indicators between good and poor outcome.

To compare outcomes of the seventy-four children I rated each child on three scales as to amount of: (1) improvement in symptoms: (2) achievement of developmental norms; and (3) antici-

pated functioning in first grade as judged by the agency staff. For the analysis of the data, the three outcome measures were combined into three outcome groups, "good," "fair," and "poor." The "good" outcome meant that the ratings had all been excellent or good on all three measures, symptom improvement, achievement of developmental norms, and anticipated functioning. The "poor" outcome meant that all the ratings on the three measures had been poor or very poor.

A case example from the good outcome group follows:

Rated excellent on all three criteria. On the whole, the child made good progress in spite of the mother's functioning on a psychotic level. His communication improved. He was able to achieve adequately in every area, including large-muscle activities. He seemed to gain a great deal of pleasure from intellectual and artistic achievements. He was expected to enjoy public school activities. His relationships with adults were on a fairly deep level and he seemed to have considerable confidence in them. His relationships with other children were good. He was quite flexible about choice of playmates and activities. No further treatment was needed for this child, but it was believed that his mother needed psychiatric treatment although she would not accept this.

For comparison, here is a case example from the poor outcome group:

Rated very poor on symptom change and anticipated functioning and poor on norm achievement. The child was judged by the staff to be still quite disturbed. He continued to lack much in the way of maintaining his own controls. He was quite provocative with other children. He continued to be unable to use adult help during times of stress. However, he had many abilities, particularly in the area of motor skills and maintained his interest in many activities and in learning new things. Nevertheless, the staff expected that the child would probably break down after the first week or so in school, so that further treatment would be necessary, probably treatment out of the home.

What I see as the usefulness of this kind of study is that it helps to partialize client characteristics which are significantly related to outcome or casework process characteristics which are also partialized. Although everything is important, we cannot understand and work with everything at once. In practice we are sometimes so overwhelmed by the amount of information we obtain that we do not have a clear idea of how to use any of it. Ego assessment may

help us to take some part of the whole and study that part in relationship to what we want to do about it.

One disadvantage for me as a casework practitioner in the particular kind of research I did was what might be called, somewhat facetiously, the lack of opportunity to work through the positive countertransference. In a belated effort to do this, let me quote from the case record of one little boy of whom I became overly fond, particularly after his reaction to the birth of his baby sister:

> When his baby sister was born his reaction was, "Now do you know what, my mother has a thin waist." He barely answered a question about the baby when we asked. He seemed to be unable to express any feelings whatsoever spontaneously about his new sister. His reaction and anxiety were all expressed in his talk about his mother's waist.
>
> He continued the next month unable to express verbally any feelings about his new baby sister, so we tried to do it for him. He started now to be very "rough" with the girls in our group. He acted as if he were going to be affectionate with them, but the hugs he gave were hard "squeezes," which hurt the girls. Several times he almost choked two of the girls. We verbalized that we understood he was a little upset about having a baby sister and that he took out his anger on the girls in our group. He was able to admit by nodding his head a couple of times that he didn't like his new sister. But he continued talking about his mother's thin waist and also made drawings of ladies with thin waists.

It seems to me that this might be taken as an example of what is sometimes called "schizophrenic" or "primitive" thinking in which a conclusion is reached illogically because a symbol which only represents the object becomes that object emotionally. That is, the symbol is not differentiated affectively from the object. In this case, the emotional charge we would expect to be attached to the idea of his baby sister is attached instead to the idea of a thin waist. To return to the Haan-Kroeber model, this is at the pathological end of the displacement-sublimation continuum. It would be interesting to work in this particular instance in connection with the body of knowledge that is accumulating in this area; that is, to study how this tendency of impulse or affect to jump logical barriers interferes with what might be termed the control of the emotions by reason and under what conditions it develops into creativity.

In other words, to work through my positive countertransference in this case I would need to get a better grasp of the current research in cognition and look into the burgeoning studies on creativity to see what could be applied to new ways of working with difficulties such as this little boy had. And this is only one example. It would seem that sufficient knowledge is already available to begin to study in pretty fine detail a variety of cognitive, affective, and behavioral difficulties and to try out new ways of working with them based upon present research in the behavioral sciences. It seems to me that social workers are in a particularly strategic position to do this because they have such a large responsibility for introducing some ameliorative resources into the lives of persons afflicted with such difficulties.

Although the little boy who was so preoccupied with thin waists was in the fair outcome group, one may wonder how he is getting along now, whether he got over his difficulty or whether it still shows up in ways that make him vulnerable to a feeling of confusion and of isolation from others. A follow-up study of this little boy and the other children I have been talking about, who are by this time in latency, has just been completed by research students at the University of Chicago School of Social Service Administration. The results of their study will contribute still more to our understanding while at the same time providing the foundation for yet further research.

Briefly, my point of view is, first, that ego assessment is useful in casework to discriminate more minutely the particular differences between people which make difficulties for them. Second, we can use the systematic framework of ego assessment to examine current research in the interrelated processes of cognition, emotion, and behavior to learn how our services may be more effectively and economically focused in the light of the new knowledge that is becoming available. Social workers seem to be especially fitted by their professional experience and motivation to make the advancement of knowledge in the behavioral sciences of practical benefit to those who want to and are able to use it.

I have speculated somewhat on the way in which advances in knowledge may feed back into practice in the near future. In one

of his letters to a colleague Freud said: "I would advise you to set aside your therapeutic ambitions and try to understand what is happening. When you have done that, therapeutics will take care of itself." I would not go so far as to say that when we understand the ego the casework process will take care of itself. Only that it is a step in the right direction.

A Social Work Model for Servicing the Chronically Ill

by ROSALIND S. MILLER

TO ATTEMPT to establish the primary issues in the field of services to long-term, hospitalized, chronically ill patients and to suggest a social work model that will formulate, define, and evaluate new concepts of practice modalities to meet these issues is a difficult task. To do less, however, will leave us with the dilemmas of, and questions about, our social work practice in hospital settings which we have been facing with a questionable degree of success for a long time.

If our programs are to be effective, we must first concern ourselves with the problems inherent in the issues which face us. If we are going to offer the type of comprehensive care we say we want for our patients, then the issues I shall discuss will affect all the disciplines, not only social work. Let us not continue to make the mistake of developing within our discipline a variety of services that "fractionate" the patient—a term we use so frequently that it has become a cliché, while comprehensive care is a goal yet to be attained.

The health professions must define the hospital setting for the long-term patient: either it is primarily a setting for the treatment and care of long-term chronically ill people, or it is a facility whose primary goal is the rehabilitation of all chronically ill patients. These two alternatives involve two different goal concepts, and the processes of patient evaluation, case planning, formulation of treatment goals, and case dispositions are very different. If I read the literature correctly, the consensus is for the comprehensive pa-

tient approach. This means that a rehabilitative program is planned for each patient at the point of admission, the possible disposition of each case is discussed at the point of admission, and each patient is periodically evaluated during his hospitalization. This approach retards in large measure the fortuitous discharge planning which often takes place several months or a year or two later. The term "discharge" may mean discharge to a nursing home, to a custodial setting, or back to the community. In other words, the patient has a "rehabilitative potential" in terms of his capacities. I am concerned because it seems that chronically ill patients are selected for rehabilitation programs on the basis of their rehabilitative potential, and thus too many patients, whose potential is not high, are treated only for their medical problems and then left on wards where just their minimum medical and nursing needs are met and there are no supplementary programs. The result is that many patients do not reach their rehabilitative potential; even worse, many regress.

Task definitions among the disciplines as they now exist often impede rather than enable the patient in the rehabilitative process. The fact is that tasks are still rigidly defined in terms of the discipline that offers the service rather than major responsibility being assigned to a member of the team who is best able to meet the needs of the patient. Will we as professional social workers really lose status if we admit that the nurse on the ward can do much in her relationship with the patient that is usually done by the social worker? Are there not many cases where the most important member of the team may be the vocational counselor, the occupational therapist, the physiotherapist, or the nurse's aide? If, for example, it is the aide who spends more time on the ward with the patient than do those from the other disciplines, and with whom the patient has the best relationship, should she not be an integral member of the team and an active participant at joint evaluation conferences? If this is so, members of the team have a major consultative role in their relations with each other and perhaps only a secondary role in direct services to patients. Can we not develop the innovative programing with growth potential which must be devised if we are to meet our goals within the ex-

pertise of each discipline, while at the same time we carefully reevaluate and reassess the tasks traditional to our training and practice? One foreseeable gain might be both conservation of our personnel and communication of our specialized knowledge to each other. Would we not also eliminate the duplication of services which often burdens the patient who is expected to relate to six or eight team members?

The hierarchical structure of medical settings does not meet the psychological, cultural, social, and economic problems of the patient. Too often, for example, physicians pay lip service to the concept of comprehensive care but allow the constant need for hospital beds to take precedence over a good discharge plan. When this situation occurs, the best case planning fails at the expense of the patient. I think this problem exists because many physicians connected with chronic hospitals have had most of their experience in the acute hospitals where the turnover of patients is more rapid. While discharge planning is equally important in the acute hospital, such planning in the long-term facility is much more formidable for the disabled patient.

Again, in spite of the generally recognized team approach to patient care, joint rounds and evaluation conferences are frequently medically oriented at the expense of functional considerations. The social work concept of the "patient in his situation" is not yet a medical concept in practice. I firmly believe that within the medical setting the final responsibility for the patient rests with the doctor; but this does not preclude the fact that the other disciplines can function effectively only within an administrative structure where they are co-responsible for patient care. This care can only be expedited when policy implementations and policy programs are developed by the multidisciplines.

No amount of interdisciplinary service will enable patients to reach their maximum recovery unless the environment is conducive to the rehabilitative process. Drab halls, pictureless walls, bare windows, empty day rooms, and lethal quiet for lack of programing, particularly in those strategic hours of 5:00 to 8:00 P.M. and Saturdays and Sundays, are for me evidence of an infectious disease which I call "hospitalitis," and they retard the healthy

motivational process as much as anything else I can mention. In other words, the milieu must be as therapeutic as the treatment. Many therapeutic models have been delineated in the literature, but we have to conceptualize even further the conditions and structure which make a therapeutic milieu. We still have not arrived at the point in our thinking where we are able to determine whether self-help or mutual help between patients is more therapeutic than, or as therapeutic as, the model in which the professional plays a primary role in motivating and enabling the patient toward maximum recovery. Talcott Parsons makes the point that in our society illness is a type of deviant behavior:

> By defining the sick person as in need of help and tending to bring him into relation to therapeutic agencies, the role of illness tends to place him in a position of *dependency on* persons who are *not* sick. The structural alignment, hence, is of each sick person with certain categories of nonsick, not of groups of sick persons with each other.[1]

That we isolate our chronically ill patients in large institutions, often outside the city, and that our communities have assumed little responsibility for our disabled population more than attests to Parsons's thesis that illness is a type of deviant behavior. How much of our society's inherent rejection of the disabled person is responsible for the apathy of many of our patients, further reinforced by some of the issues which I am outlining, must be acknowledged and understood as we attempt to find new models for developing the therapeutic milieu.

We have still to develop a meaningful problem classification of our chronically ill patients. After long periods of hospitalization they may not have changed in appearance, yet frequent evaluation based upon a dynamic, diagnostic understanding of the individual would indicate that there are two categories of patients. For one group, chronic illness is just another chronic problem added to the host of problems and deprivations with which they have had to cope: inadequate education, erratic employment, economic insecurity, poor housing, family disintegration, alcoholism, and so on.

[1] Talcott Parsons, "Definitions of Health and Illness in the Light of American Values and Social Structure," in E. Gartly Jaco, ed., *Patients, Physicians and Illness* (Glencoe, Ill.: Free Press, 1958), p. 178.

The patients in the second category arrive at long-term facilities after months of illness, probably in general hospitals, and for this group, loss of employment, economic stress, and family difficulties are results of the illness.

Good psychosocial diagnosis should help us differentiate between these two types of patients. With the latter group, where the prognosis is often more positive than for the first group, good treatment planning should result in returning a larger percentage to the community. For the former group, many of whom have no homes to go back to and no families, there is little motivation to return to the community. Case planning for this group is equally important; realistic goal setting may mean custodial care for many of them.

So long as we continue to offer services to the patient on the ward without recognizing that this is only half a service and that the other half extends into the community, we shall continue to see the poor results which we have experienced with chronically ill patients who are unmotivated for taking part in community living. If we talk about total patient care, we must speak of it in terms of finding how to bridge the gap between hospital and community and between the community and the hospital. Community organization and planning are as integral to our service to the patient as casework and group work services are to patients on the ward. In practice terms, this means an active involvement on municipal, state, and even federal levels with legislation which directly affects our disabled population.

The vast majority of our patients, both in custodial settings and in the community, are maintained on public assistance programs. Many welfare procedures deny patients their rights, thus causing hardship as well as impeding medical planning. Some of our problems in New York City are caused by Department of Welfare procedures which require that a case be closed after a patient has been hospitalized for three months. This usually means that he will lose his apartment and his effects will be stored. A patient under sixty-five who is not on a special assistance program is denied a monthly allowance. Consequently, many ambulatory and wheel-chair patients cannot purchase a daily newspaper, a cup of coffee at the

hospital canteen, or even a candy bar. Patients in our Home and Infirmary who need wheel chairs, dentures, eyeglasses, or prostheses wait three, four, five, and sometimes six months. How long is the social work profession going to tolerate bureaucratic structures which pauperize patients and deny them their rights to benefits provided by law? Complaining solely among ourselves says very little for our professional obligation and even less about our responsibility to the patients.

We cannot expect to achieve comprehensive medical and social care either in the hospital or in the community until we recognize that the separation of medical and welfare services is more detrimental to the patient than the problem which would ensue if these two services were combined. I know the argument against this proposal is that the larger the bureaucratic structure, the more difficult it is to expedite programs. What we have now are two structures, one of which examines the medical needs of a patient while the other considers his financial needs and in which both duplication of services and lack of services are commonplace.

If we are concerned, as we should be, with the question of how we can make the community responsible for its disabled population, we should find the answer in developing programs between hospital and community to coordinate services.

We can begin to accomplish this aim if we do not duplicate within the hospital services that can be provided by agencies in the community. There are many voluntary agencies which have special expertise, knowledge, and programs to meet the specific needs of the disabled patient. There are, for instance, agencies which work with the handicapped, the blind, the alcoholic, and which offer training programs, sheltered workshops, recreational groups, and employment programs, all of which would be of tremendous benefit and of great motivational value to many of our patients who remain in hospitals and institutions more for social reasons than for medical reasons. If hospitals purchased program and staff time from these agencies, many patients could profitably utilize the programs during the day and return to the hospital at night. For those who would eventually be discharged from the hospital, the necessary bridges would thus have been built, in addition to

the usual planning for housing and out-patient clinic care which have been our primary concerns. This type of programing would help to broaden the service base of the voluntary agency as well as begin to close the gap between the municipal agency and the voluntary agency.

Finally, and most important, no innovative program developed by the multidisciplines, and certainly no new social work model which encompasses any of these issues, can come to fruition unless the organizational system of which it is a part supports an operational model which makes all this possible. Social work's biggest frustration in the host setting has resulted from two inherent problems: (*a*) social service departments have been ancillary services, which has made them, by and large, impotent; (*b*) many new programs which social service has attempted have not met with success because they have not received the support of the organizational system. It should be perfectly clear to anyone that unless the system within the hospital setting makes a total commitment to the utilization of the multidisciplines we shall continue to have the problem of fractionated patient care, team discontent, and, most important of all, unmet needs of the patients.

Several years ago, the former Commissioner of Hospitals in New York City, Dr. Ray Trussell, was given the task by Mayor Wagner of drawing up a plan whereby the municipal hospitals could upgrade their staff and their services. It was Dr. Trussell's idea that if municipal hospitals became affiliated with medical schools and teaching hospitals, it might be possible to attract professional personnel of high quality and thus ensure better patient care. Under this plan, the largest municipal hospital for the chronically ill in New York, the Bird S. Coler Hospital, became affiliated with the New York Medical College, Flower and Fifth Avenue Hospital. In June, 1964, New York Medical College came to Columbia University School of Social Work and suggested not only that we develop a model for a social service department but also that we staff and operate it. While schools of social work do not normally go into practice, the faculty had been concerned with questions involving curriculum, field work placements, new approaches to practice, teaching materials, and a host of other questions; and so

it seemed that there could be no better way to approach some of these problems than to develop a practice setting which would provide the means to test our ideas.

In June, 1965, I became Director of the project, and the department went into operation in September. Let me say one word about my use of the word "project." Medical schools that have assumed responsibility for municipal hospitals receive affiliated funds from municipal, state, and federal funding programs. The School's contract with New York Medical College is for three years, renewable at the end of that time. I mention this because we do not see this venture as a demonstration project but rather as a program which is an integral part of the hospital.

Unlike most social service departments in hospitals, staffed primarily by medical and psychiatric social workers, this department is staffed by workers in all four methods: casework, group work, community organization, and research. Since this is a policy-making department, I work closely with other chiefs of service in the development of administrative policies and procedures. Obviously, we are in the hospital to give service to patients, but if a social service department is to be effective it must first decide what kind of service to offer. There are two ways to answer this question: one is to develop a program on paper and then set about activating it; the other is to recognize that in a 1,600-bed facility an initial observational and practice experience should precede an operational plan. For the first six months our staff observed, offered a variety of services, and familiarized themselves with the setting. Only then did we begin to formulate a workable plan. When we began, we chose four medical services as different from each other as possible in which to offer our own services. On all other wards, only emergency social service was offered. It seemed to me, however, that if we were to have a useful program, we would have to concentrate our energy rather than give helter-skelter service in such a vast setting.

If our goal is comprehensive patient care, this means that we are interested in preparing the patient and his family for his admission into a chronic-care facility, planning for the patient while he is in the hospital, making a discharge plan when he is ready for the

community, and following him through his first months at home.

Pre-admission service.—At the present time a supervisor and one social worker have been assigned to our Department of Community Medicine, where the initial emphasis is on a team approach by the public health nurse and the social workers, who spend half of their time in the three general hospitals from which we receive 75 percent of our patients. This team meets with the attending doctors on the wards of the general hospital where patients are recommended for consideration for our facility. The public health nurse does an ADL (activity of daily living) evaluation while the social worker explains to the patient why he should consider transferring to a chronic hospital. Where families are available, the social worker makes an initial contact and interprets to them the reasons for the transfer. We feel that with this approach patients feel less anxiety and anger than when they are shifted from one hospital to another with little preparation. Recommended patients are then presented at an admission conference in the Department of Community Medicine to a committee composed of the Director of Community Medicine, the chief of a medical service, the public health nurse, and the social worker. Our task here is to offer significant psychosocial material to the committee which will help to determine whether or not the patient is a candidate for a chronic hospital. Finally, an initial psychosocial summary is available to the admitting ward personnel prior to his admission.

Ward services.—The medical part of our institution initially contained twenty wards with fifty patients per ward. In order further to facilitate the concept that the patient has a personal physician, these wards were divided into four units of 250 patients, each with its own medical chief and four doctors, the nurse clinician, nursing personnel, and the nurse's aide. At the present time we are developing differential staffing patterns in the social service department in order to define and evaluate tasks for four types of social service personnel: the professional social worker; the preprofessional (social work assistant); the part-time volunteer; and the indigenous worker. One unit will be staffed in a more traditional professional social work pattern, and three units will have a staff combining other social service personnel. Eventually, our re-

search department will evaluate these staffing patterns and services in order to assess their relative effectiveness. In preparation for this we began on April 1, 1966, an in-service training program for nine social work assistants. These assistants have been assigned to a supervisor for a training program which includes daily lectures and seminars as well as assignment to cases on the wards which will utilize the knowledge they have acquired. At the end of three months these assistants can be redeployed to certain medical services, at which time we will assign them to a variety of tasks under varying kinds of supervision.

Home and Infirmary.—The other section of our hospital, the Home and Infirmary, houses from 600 to 700 patients who need only minimal medical and nursing attention but who, for various reasons, may live in this custodial setting for extended periods. At this point we do not know how many are there primarily for social reasons, but I would hazard the guess that lack of family, rejection by family, lack of financial resources and of jobs are largely the reasons that these people are in the Home and Infirmary.

One question we have asked ourselves is: What is this building? Is it an integral part of the rest of the hospital or is its function that of a domiciliary setting which should be administered outside the hospital organization? In order to determine the characteristics of this group and to understand some of their needs, we have instituted a community development project in which we are examining this part of the hospital as a community with few resources. In other words, we are defining this building much as one would define an underdeveloped country or a depleted town in Appalachia. We have applied for twenty VISTA volunteers who will spend a year working with our patients, bringing them to the gradual recognition that they may have some problems whose answers might be found in self-help programs and in new resources within their community. The other half of this project calls for ten indigenous workers from the community whom we call Coler Community Agents. Although they are based at the hospital, their primary responsibility will be to follow the patient into the community at the point of discharge and to be available through those first few

critical months when he has been relocated in a foster home, hotel, or furnished room and to help him make use of the resources of the community so that he can function in the outside world. These resources include home-care programs, out-patient clinics, sheltered workshops, vocational programs, and recreational facilities. Our goals are twofold: to enable the long-term hospitalized patient to adjust more easily in the community; and to develop a career line for the indigenous worker which will meet manpower needs in the health profession.

Community organization and planning.—If we ask ourselves how the community can be made to accept this responsibility for its disabled population, then we must find ways to bring community agencies into the hospital setting. We have developed one such program with a voluntary agency whose particular focus is on work with the blind. In September, 1966, a worker from that agency will be assigned on a full-time basis to our hospital to evaluate some 100 or 150 blind patients from whom will be selected the ones who can benefit from the many programs this agency conducts. These patients will go to the agency during the day, and Coler Hospital will become for them a night facility. Programs which will include instruction in how to travel with a cane, activities of daily living, sheltered workshops, and recreation will be offered to them. When these patients are ready for discharge, they will have acquired the necessary supports. Our goal is to demonstrate that collaborative planning by two agencies eliminates duplication of service and links the chronic facility to the community resource. For those patients who need custodial care and must remain in the Home and Infirmary, the agency's role will be that of working with our staff to provide programs that will better meet their needs. We will continue to work out similar kinds of programs with other types of agencies.

The vast majority of patients who live in the Home and Infirmary are supported by the Department of Welfare. It is necessary and desirable that we work collaboratively with the many bureaus which compose the Department of Welfare, many of whose policies and procedures impede services or cause hardship to our pa-

tients. We have been working intensively with the directors of the several bureaus to find ways to adjust their procedures so that they may more realistically meet the needs of our patients.

Research.—The first research project we undertook shortly after we began our program at Coler Hospital was a demographic and career study of the total patient population in order to obtain some understanding of who these people were and where they came from, their ethnic background, family patterns, length of hospitalization, and their movement within the hospital. This data will enable us to develop the research designs in the units where our social service staff will be giving a variety of services. In these units as well as on other wards, our goal is to pursue research through the systematic collection of data.

Other plans too are in the making, such as those for a weekend foster home program in our children's unit for children who are unable to return to their own homes for weekends, in-service training which will enable our staff to provide group work as well as casework, development of a variety of job definitions in order to try out new service patterns as well as new patterns for supervision and/or consultation, and for the introduction of field work placements.

The model I have outlined for a social service department in a hospital for the chronically ill extends beyond the four walls of the institution. We must not be contented with our *service* orientation. We have the technical skills, the knowledge, and the competence to make a systematized, organizational approach to the problems of our disabled population. Unless we become actively involved in social welfare programs, social policy and legislation, and social action planning, our services to patients will continue to be only half realized. The need to move in these directions is even greater now that Medicare is a reality. John B. Turner observes that

> we have continued to promote program and services for problems which are not essentially individual problems, but problems of our social, economic, and political structure.
>
> As long as this bias prevails, it will interfere with effective management of social problems and will, of course, do little to prevent the

dysfunctional consequences to individuals stemming from social and technological change. . . . We must learn to present more effectively the case of institutional inadequacy and thus institutional change as a concept of social progress.[2]

The issues I have delineated are not new; we have lived with them too long. Social workers must assume their responsibility for initiating, formulating, and conceptualizing solutions to the problems inherent in these issues. We have either been contented too long with too little for our patients; or, if we have been discontented, we have gone, in Quixote-like fashion chasing windmills. If we are to realize our service goals, then we must build our windmills.

[2] John B. Turner, "Relation of Health and Welfare Planning to Social Change and Social Development," in *Social Work and Social Planning* (New York: National Association of Social Workers, 1964), p. 18.

Efforts to Involve the Poor in Social Action

by DAN MORRIS

WITH THE PASSAGE of the Economic Opportunity Act in the fall of 1964, the principle of maximum feasible participation of the poor in community action programs was introduced as a new concept of social policy. In New York City, as elsewhere throughout the country, much confusion was created, and there was heated controversy as to what this meant and how it would be implemented. The heat of the argument was quite understandable since it was implied that both power and money were to be shared by the established political and private institutional forces with the poor. This feeling reached a crescendo with the publication of a statement made at the United States Conference of Mayors in June of 1965 which accused the federal government of "fostering class struggle" through the community action programs. In late winter of 1965, New York City announced tentative plans for the selection of a small number of representatives of the poor who would serve on what appeared to be the central planning and policy-making group for the city's poverty program. The city also described in somewhat general terms the concept of city-wide coordinated community progress centers tied into an over-all city structure. These announcements followed hard on the heels of the attack upon Mobilization for Youth (MFY), whose programs emphasized the organization and involvement of the poor in creating new services, improving existing services, and effecting changes within public institutions whose practices affected the lives and destinies of the poor. These efforts frequently resulted in

criticism and direct action by local groups against these institutions. The stated charges against MFY were "Communist domination" and "administrative mismanagement." These charges were shown to be false, however, as witnessed by a very carefully worded public statement carried in the New York *Times*.[1]

Many informed groups and individuals believed that the attack was in fact aimed at destroying or neutralizing the social action focus of the program which appeared to threaten the established political group and its institutions. The city's poverty plan was interpreted in many quarters as an extension of the attacks on MFY, an attempt to create a poverty program that could be safely controlled by the local government. The announcement of the city's plan brought forth vigorous protest and a campaign by a coalition of the poor, their representatives, interested social workers, and a group of influential citizens who argued for majority representation of the poor on the city's poverty council and for the autonomy of the local community programs.

The campaign was partially successful in its efforts to increase the number of representatives of the poor to the Poverty Council and probably had the parallel effect of protecting some degree of local autonomy for the community committees. The basic issue, however, as to who would "develop, conduct, and administer" the poverty program was not resolved.

In the early spring of 1965, MFY was asked to select two representatives of the poor to serve on the New York City Council against Poverty. MFY declined the invitation, explaining that it was not yet representative of the poor. A substitute resolution was passed by the New York City Council against Poverty charging MFY and two other community action projects with responsibility for submitting a plan for the election of a community committee. The plans submitted were to reflect, but not necessarily follow, the election guidelines set by the city. MFY decided to involve the community in devising its own plan for a community committee. (In this context a community is defined as a large population living within a distinguishable geographical and sociological section of an urban area—in this instance New York City.) MFY felt that

[1] New York *Times*, October 3, 1965.

this was a right given to the poor under the spirit and letter of the law. It was also believed that this direct community involvement could help start the building of what Mogulof describes as a "competent community":

> What is a competent community? For one, it is a place where the leaders are of the people and are a power in affecting the decisions of all those agencies that provide resources to that community. In low-income communities it is a place where the neighborhood representatives know how to deal with the police and courts, how to make their public schools aware that the price of the continued failure of their youth will be high, and where the welfare department, housing agencies, and so on know they are not dealing with a supine mass. Do such communities exist? Probably not, but that they must is clear, especially while the United States has a large "underclass" dependent for most of its resources and opportunities on the decisions of public agencies.[2]

In May of 1965, MFY implemented its decision by helping an *ad hoc* committee (consisting of representatives from small local grass-roots groups, clergymen, and local residents) begin devising an election plan. MFY provided the committee with a staff member and clerical support. The responsibility of this *ad hoc* committee was to hold a community election for a steering committee, whose function would be to devise the final election plan. This plan would then be submitted for approval to MFY and eventually to the appropriate city poverty committee for final approval.

Starting in August, 1965, and concluding in December, 1965, with the election of a thirty-man steering committee, a series of three community meetings were held. The forces in evidence at the meetings were: (1) local groups of the poor, which existed prior to the election; (2) local political groups, primarily progressive and left-wing organizations; (3) a significant number of church groups, especially from the Catholic Church; (4) ethnic groups, predominantly Puerto Rican and Negro; (5) local community councils organized along geographical lines, primarily representative of middle-class and lower middle-class groups; (6) minor involvement and observation by local traditional social agencies, primarily settlement houses; (7) a small group of indi-

[2] Melvin B. Mogulof, "Involving Low-Income Neighborhoods in Antidelinquency Programs," *Social Work*, X (1965), 56.

viduals representative of all the aforementioned groups, relatively devoid of vested interests and concerned solely with a fair election process.

The potential power of the community committee released within the community a full-scale mobilization of political forces. During the pre-election and election period there were many charges and countercharges, running the gamut from the claim that there was a stacked *ad hoc* committee, a biased chairman; the settlements want to dominate, MFY wants to dominate, the Church wants to dominate; there's delay, there's railroading; the voting procedures are unfair; there's too much interpretation into Spanish, there's not enough interpretation into Spanish, there is bad interpretation into Spanish; to claims that the ballots were mishandled, and so on. There were enough partial truth, confusion, and problems involved in having a relatively inexperienced group of local people run an election to give credence to some of the charges. The predominant theme in all the political jockeying, charges, and countercharges was concern about which group or coalition of groups would control the poverty program for the Lower East Side. For the moment, the issue of what kind of poverty program there should be was lost completely in this main struggle. In my view, this did not differ from any other struggle for power that I have witnessed, except in its style. The poor were not so polished or so sophisticated as the "pros" in running their political campaign.

With the election of the committee in December, the community settled down to a period of watchful waiting, and the steering committee went to work on formulating a plan for the election of the community committee. Between January 1, 1966, and April 1, 1966 (the time it took for the steering committee to devise an election plan), the committee functioned almost totally independently of MFY. As they approached their job, the special interests and group affiliations of the committee members became less of a factor in decision-making, and the committee began to develop a loyalty to its own function and goals. This process is continuing but still has a long way to go before loyalty to the committee becomes the dominant force.

The final plan evolved by the committee was approved by the MFY board and the New York City Council against Poverty in April of 1966. The eight district elections to choose the Lower East Side Community Committee are scheduled for June 5, 1966.

The election plan prepared by the steering committee was well thought out, carefully prepared, and unique in its emphasis on the involvement of the poor. A comparison of the city's election plan and the committee's plan illustrates this. The essential differences between the two plans were as follows:

1. The city required that only delegates from recognized organizations in the community could nominate candidates and vote. The steering committee required only that people be residents to nominate candidates, run for office, and vote.

2. The city required that a minimum of one third of the final sixty-member committee should be drawn from the poor. The steering committee required that all the elected forty representatives be from the poor. The remaining twenty members would then be selected by the elected group regardless of income. This requirement squarely gives control of the committee to the poor.

3. The city defined "the poor" as people having a maximum income of $3,000 to $5,000, depending upon the number of dependents. The steering committee defined the poor as people with a total maximum family income of $6,000.

A recent study[3] of ten community committees elected under New York City's guidelines showed that the median income of the elected delegates is between $6,000 and $8,000, nearly three out of ten earn over $10,000, and only 3 percent have incomes under $3,000 (exclusive of eight Catholic priests and one nun, all of whom earn less than $3,000). The study also indicated that the typical delegate is a college graduate. Only 3 percent have less than a grammar school education; 85 percent have completed high school or attended college and graduate school; 29 percent have graduate degrees. The ethnic backgrounds of the elected delegates are: 45 percent white; 37 percent Negro; 18 percent Puerto Rican. An analysis of the thirty-one members elected to the steering com-

[3] Claire P. Fishman and Preston Wilcox, "Analysis of Delegates Elected to New York City Community Committees" (unpublished paper).

mittee showed that: the median income is between $4,500 and $5,500; three out of ten earn under $4,500; 21 percent earn $3,000 or less; 31 percent completed high school or attended college and graduate school. The ethnic backgrounds of these delegates are: white, 10 percent; Negro, 37 percent; Puerto Rican, 48 percent.

Candidacy for office and voting for the steering committee were on an individual basis (the same requirement for the election of the community committee) rather than by group affiliation as in the elections conducted by the city. This procedure was the prime factor responsible for electing a committee that would be representative of the poor. The poor are not at all organized, as are most affluent groups. Voting based upon, and weighted by, group affiliation can only produce a more affluent committee. Based upon a preliminary analysis of these studies, it seems evident that the city plan gives major representation to the more affluent, better educated, majority group residents of the community, and, in effect, control of the poverty program. The steering committee's plan will do just the opposite.

An evaluation of both the abilities and the limitations of local residents participating in this social action would indicate the following:

The capabilities of the steering committee were manifold. With minimal support they devised a rather complicated and sophisticated election plan that was accepted by their own members, the community action agency, and the city. The support they needed was primarily clerical, administrative, and informational, with occasional advice. It is impossible to assess accurately the impact of MFY's guidelines for the election on the committee's final plan. The essential recommendations were: (1) a significant majority of the committee should be from the poor; (2) the income definition of the poor should be raised above the city's definition; (3) voting should be by residents only and on an individual basis. These were the essential recommendations. Both the ideas embodied in the guidelines and the power of MFY to pass upon the plan may have had a very significant influence upon the steering committee. An important limitation of the committee in this action was its inexperience in navigating the city's policies and procedures.

Another point at which they needed guidance was in developing plans, complete with timetables, deadlines, and alternatives. In preparation for the actual election they needed a great deal of technical assistance. I would emphasize the importance to the group of the clerical, administrative, and information services that MFY provided. These services freed the members, whose time was limited by work and family responsibilities, to devote their energies to the important rather than the menial tasks.

This was a very capable group, able to handle the job with a minimum of staff support and guidance. However, let me caution against generalizing from this example or romanticizing the abilities of the poor. An analysis of the backgrounds of steering committee delegates shows that five of the members were clergymen experienced in organizational work, organizational politics, administration, and community life. Twelve of the members were middle-income people (lower brackets) with similar experience. Seven of the members were representatives of the poor, also with considerable community experience; eleven members were poor (those with incomes under $4,000 include two clergymen). This is not, in my estimation, the prototype of a grass-roots group of the poor such as one would find in a tenants' council, a welfare clients' group, or a block organization. If we were to contrast the aid required by the steering committee with the aid required by a group more typical of the unorganized poor, we would find the following: [4]

1. The unorganized poor require a high degree of aggressive direct leadership to help them organize and to sustain their action. The worker's role must be a combination of advocate, "backbone builder," direct leader, teacher, lawyer, and only occasionally that of social worker enabler. With the steering committee, the staff worker was much more the enabler.

2. The unorganized poor, except in crisis situations, organize around "bread-and-butter," "concrete" issues. People whose lives

[4] The comments are based upon the discussions in a group seminar held with the MFY community development staff. Staff members participating were: Petra Santiago (Mothers' Group), Ezra Birnbaum (Welfare Clients Group), Leslie Sherova (Neighborhood Block Group), Ed Pitt (Federation of Negro Groups), and Daniel Kronenfeld (supervisor).

center on survival and crisis are not able at the outset to consider the broad social and political problems that confronted the steering committee.

3. The unorganized poor require direct services, such as help with housing, family problems, health, welfare, child care, and so on, in order to function. The members of the steering committee required none of this support.

4. Leadership within groups of the unorganized poor is usually developed through the slow and painstaking efforts of the worker to teach, train, and demonstrate leadership techniques. Natural leadership was plentiful within the steering committee.

Both groups require very active administrative aid, clerical support, and technical assistance focused upon the social action in which they are involved.

One final comment about the aid needed by the steering committee: the action taken by the committee was not social action complete with strategies, politics, confrontation, and potential conflict. Nor was it the total type of planning, coordination, and community organization that the community committee will eventually have to undertake. To enter upon these more demanding tasks, the community committee would require, in my estimation, full-time staff support, a much more active, more challenging, and more direct staff role, and technical assistance available on a consistent basis.

Providing the aid necessary for local groups to engage in social-action programs is frequently quite expensive. The results are oftentimes not clearly visible, the returns frequently small and a long time in coming. Success is not insured by patience, good intentions, or even by sound professional practice. Firm conviction on the part of the community action agency is therefore a vital prerequisite to undertaking an assertive community development program. The legal mandate of MFY was to develop its own plan for a community committee for the Lower East Side of New York City. Its decision to give this responsibility to the community and to support the community's efforts was borne out of conviction that the poor should be maximally involved in "developing, conducting, and administering" the poverty program.

MFY envisioned a community committee composed predominantly of residents who were poor or closely identified economically and socially with the poor. The committee would have the responsibility, authority, and sufficient financial resources to plan and coordinate a comprehensive poverty program. The program would provide needed services and attempt to attack the root causes of poverty through community action programs.

The committee would be tied to the larger parent body, the City Poverty Program, and together with the other community committees throughout the city would participate in an influential and effective manner in planning and coordinating the city's poverty program. Without this connection with, and an authoritative voice within, the city-wide program, local control is ineffective and wasteful, resulting in duplication of efforts, an uncoordinated program, and continuation of the lack of thoughtful planning that has plagued the poverty program.

This concept of a community committee is, at best, a very difficult, almost monumental goal to achieve for three reasons:

1. An inherent shift in power is required in order to activate the idea and the countering forces this will stir up.

2. Operating a successful community committee is a complex task by itself. Doing so with a group composed primarily of the poor will be more difficult due to their inexperience, their lack of organizational know-how, and the potential temporary psychological side effects of assuming a new role.

3. The creation by local communities of meaningful programs that will get at the basic causes of poverty is not easy. Small group programs, such as day care centers, reading clinics, consumer clubs, and so forth, have their place, and an important one. However, the local programs have to deal with core issues like jobs, education, housing, in order to be effective. This requires central planning and coordination and, at the same time, a significant degree of local planning and participation—difficult concepts to administer simultaneously.

So far as item 2 is concerned, there is the initial problem of inexperience and lack of formal training among the poor. I have lit-

tle doubt, however, that they, like any group, can develop competency if opportunity and aid are extended to them.

This view would be supported by the community development staff of MFY. Ezra Birnbaum, in an unpublished paper, "Organizing the Poor," describes the development of leadership and the social action program of a group of welfare clients. In only eight months the group accomplished the following:

1. Grew from membership of eighteen to over five hundred.
2. Had two meetings with the Welfare Commissioner with positive concrete results.
3. Produced specific help for its members, including some significant administrative changes within the welfare department.
4. Conducted a very successful twelve-session leadership training program for some fifteen or twenty members, with a waiting list of another twenty.
5. Sponsored and successfully conducted a city-wide all-day conference in preparation for city-wide action and the possible formation of a city-wide organization of welfare clients.

These efforts and results required leadership, organizational skills and the ability to translate ideas into concrete programs. The leadership and program would not have happened without the conscious, skillful work of the professional to develop both group and individual abilities and capacities. The potential had always been there, dormant for many years.

One last comment about the competency of the poor. In the words of Ed Pitt, one of the community development workers at MFY:

> Why should there be a double standard for the poor? The professionals, politicians, and their representatives have far from distinguished themselves in the poverty program. Why should the question of demonstrated prior competency be required of the poor? It is not required of other groups. Give them the same chance to learn, administer, and make mistakes as any group and they will come through.

There are many professionals who, with good cause, would take strong exception to the thesis that within our present system MFY's model of a community committee could be achieved. They

would point to: (1) the political realities—politicians fear a new politically independent force; (2) the doubt that funds from governmental sources could be fully and freely used to affect significant social change; (3) the untried ability of the poor to take on this major task; (4) the question whether well-established institutions, both private and public, would relinquish their power; (5) the complexity and enormity of the factors producing poverty that cry out for massive economic solutions and make local efforts ineffective; (6) the relatively small sum of monies available to wage an all-out, significant war on poverty; (7) the possibility that the leadership of the poor could be "bought off" by jobs and the rarefied atmosphere produced in the high councils of the professionals, lay leaders, and politicians; (8) the theory that one cannot change a social system while one is a part of it.

There is much truth in what these professionals say, and history may well prove them to be correct. The hope and the goal of MFY were that with effective programs, and sufficient pressure, these factors could be altered sufficiently to make the community committees work effectively.

Informed opinion on the desirability and feasibility of allowing the poor to develop, conduct, and administer the poverty program runs the gamut for a wide variety of reasons, which I shall not attempt to enumerate. In some quarters there is the kind of concern that was expressed in the New York *Herald Tribune*'s editorial of April, 1966, which condemned the booing of Sargent Shriver at the Citizens Committee against Poverty convention by what the *Tribune* described as "so-called grass roots groups, unhappy at not having been given what they consider enough, soon enough," and called for control of these "disorderly elements" in the poverty program.

No responsible professional would condone or support this behavior. The *Tribune* does not attempt, however, to analyze why the outburst took place, as does the *New Republic* in an editorial which says in substance that Sargent Shriver should have known better than use statistics to convince the poor that the poverty program was working. The poor evaluate the program, using their own very personal guidelines, in every slum and ghetto from New

York City to California. Nobody takes kindly to feeling that he is being controlled or used. The editorial goes on:

> The liberal coalition leaders would like to harness the force of protest from below to elect candidates, strengthen unions, or simply put the fear of violence behind their own demands. But they are not at all sure they want an independent force on their hands.[5]

This is a crucial point, and one that social workers and liberals who espouse the cause of maximum feasible participation of the poor must look at, and look at honestly.

For us to begin to think in terms of the competent community and an effective community committee structure requires a shift in our social philosophy and in the social systems that deliver social services. It may well be a long time in coming. This is not to suggest that merely changing our social philosophy will in some magical way produce jobs, change our educational system, eliminate slums, provide medical services, and alter the basic factors that create poverty in our nation. Many questions remain:

1. How can we provide the economic resources to wage a significant poverty program and secure the continuing economic climate to support its effectiveness?
2. How can we solve the many technical and professional problems of education and vocational training as well as change deeply ingrained attitudes?
3. How can local communities develop, conduct, and administer the program and still have an intelligent, coordinated, and planful poverty program emanating from the federal and local governments?
4. How can we provide technical assistance, expertise, and supportive services without letting the "pros" dominate the program?
5. How can we meld the diverse ethnic, sectional, economic, and social groups into a coordinated effort toward a common goal?

These questions have to be answered regardless of what philosophy and administrative system guide the poverty program. A program that seeks the solution to these and other questions with the active engagement and honest involvement of the poor has the potential for a deeper, more fundamental success.

[5] "By or for the Poor?" *New Republic*, April 30, 1966, p. 6.

Services for the Widowed during the Period of Bereavement

by PHYLLIS ROLFE SILVERMAN

ALL OF US HAVE BEMOANED the fact that clients come to us only when they are in crisis. We would prefer that they ask for help before their lives become so chaotic and disorganized. However, the call for help perhaps can only come when there is a crisis, a breakdown in functioning, and an inability on the client's part to cope with the situation in which he finds himself. A problem arises for the worker, as he tries to meet the needs of the client, because of the way in which the worker looks at this crisis. The conceptual scheme by which most of us examine the problems of our clients leads us to seek the etiology of these problems in their early childhood experiences. The service we have available—casework is designed to help the client with his malfunctioning, which is a reflection of personality or interpersonal difficulties that result from his psychosocial developmental experience.

As caseworkers, we are at a further disadvantage because of the way in which our services are organized. A client comes to us only at certain points in the life of his problem: when he has decided to seek help, or when he happens to talk with someone who makes a referral, suggesting that our service may ameliorate his situation. The methods of intervention available to the worker may not be sufficiently varied that he can do anything about the changing aspects of the client's current problem. Casework is an attempt to lift a problem out of the living process and look at it under "laboratory conditions," and we may, therefore, miss the movement and change in the problem.

Crises seem to have a life of their own, and the problems people bring to us would look different if we considered them in terms of the crisis itself. Some of the solutions we would offer would vary as well, depending on what point in the crisis the client met the social worker.

The concept of crisis has been applied in mental health practice, primarily in the development of programs of primary prevention. Caplan [1] refers to normal critical transition periods in people's lives which require them to make new adjustments in order to meet a new situation. Drawing on the work of Erikson, he looks at the transition of an adolescent into young adulthood, the arrival of the first baby, the loss of a job, a death in the family. He points out that the way the individual will cope with the demands of the new role he assumes will have impact on his subsequent mental health. In a program of preventive intervention we help people early in the critical period to cope more effectively and efficiently. We hope to influence their subsequent adjustment and thus prevent emotional disorders.

I would like to use the concept of crisis in looking at programs of secondary and tertiary prevention as well. Most casework is at these levels; that is, we treat people who already are in difficulty or we try to rehabilitate them from the residual effects of the difficulty. It seems to me that in casework we are seeing people at different stages of a crisis or critical transition and that if we understood the stage of the transition they are going through, we would be able to treat them more efficiently and effectively.

The word "crisis" does not adequately express the meaning in which it is currently used. Webster defines "crisis" as (1) a turning point for better or worse in an acute disease or fever; (2) an emotionally significant event or radical change of status in a person's life; (3) the decisive moment, as in a literary plot; and finally (4) an unstable or crucial time or state of affairs. It may be used in terms of a specific moment or turning point, and in terms of an extended time period as well. I prefer, therefore, the phrase "critical transition," which implies a period of time as well as a

[1] Gerald Caplan, *Principles of Preventive Psychiatry* (New York: Basic Books, Inc., 1964).

turning point, and applying the word "crisis" to a specific event or moment of turning in the transition.

A "critical transition" can be defined in three dimensions:

1. First there is an event, or series of events, which has a disequilibrating effect on an individual and which taps his ability to cope.

2. A period of time is involved; that is, there is a process that has a beginning and an end between which the individual does the "work of the transition." [2]

3. The transition involves a turning point for the individual.

A fourth point which may be added to the definition is alluded to by Caplan and supported by Rapoport,[3] who suggests that these transitions always mean status change for the affected individual, thus necessitating a redefinition of the role he performs in his social network.

The work required in a transition may be related to the suddenness of the onset of the crisis, the amount of loss to the individual, and how much his life is touched by the situation. Is there a total or a partial change, and is it temporary or permanent? Regardless of the nature of the crisis, however, the critical transition seems to occur in phases or stages. Tyhurst, from studies of individual responses to community disasters, to retirement, and to migration, has identified three overlapping phases. He calls the first phase the period of "impact"; the second, a period of "recoil"; and the third, "posttraumatic," or the period of "recovery." [4]

The period of impact is when the crisis or catastrophe occurs, such as a flood, or the act of retiring, or a death. The full and direct effect of the initial stress is experienced, and there are characteristic reactions; people restrict their field of attention, seem stunned, and unable to come to grips with what has occurred. Their time orientation is to the immediate present.

During the period of recoil the individual achieves his first full

[2] I am indebted to my colleague Henry U. Grunebaum, M.D., who coined this phase.

[3] Rhona Rapoport, "Normal Crises, Family Structure and Mental Health," *Family Process*, II (1963), 68–80.

[4] J. S. Tyhurst, M.D., "The Role of Transition States—Including Disasters—in Mental Illness," in *Symposium on Preventive and Social Psychiatry* (Washington, D.C.: U.S. Government and Printing Office, 1958), pp. 149–69.

awareness of what has happened, and there is a period of personal turmoil as he realizes the changes that have taken place. The first real, overt expression of emotion comes during this time. The individual is still oriented to, and preoccupied with, the past.

The period of recovery is marked by the feeling that the stress is passed, and there is a reintegration in terms of the individual's new situation and his past adjustment. He develops a new set of functioning roles. Once again he is oriented to past, present, and future.

The work of transition is to move from one stage to the next. In order to understand how an individual is coping with a critical transition, it is as necessary to know the present stage of transition as to have his past history.

At the Laboratory of Community Psychiatry of the Harvard University Medical School concern with the problems of crisis and critical transitions was stimulated by our interest in programs for the prevention of mental illness. The problem of bereavement was chosen as the focus of study because it represents an accidental critical transition in the life of an individual. It was found that younger widowed persons have a higher risk of entering a mental hospital than would be expected for their number in the population. The younger people reported serious physical symptoms, often psychosomatic in nature, such as lower back pain, headache, insomnia, and the like.

Much of what is known in the psychiatric literature about the processes of mourning has been learned from patients who requested help, and we can assume that they would have had a poor outcome. A study is now going on at the Laboratory to learn what happens in the general population of younger widowed people to see what effect various patterns of coping will have on their future adjustment. They are being interviewed three weeks, six months, and one year after the death of the spouse. We hope to develop a general profile of how people cope with grief, the subsequent transitions, and what kinds of outcome this leads to.

Because of our interest in prevention, which would entail a program of direct service, I was asked to investigate how the needs of the people in this population are met currently in the community

and whether it would be possible to set up a service that would meet these needs.

Freud said, "The function of mourning is to detach the survivor's memories and hopes from the dead." [5] When mourning and bereavement are viewed as a critical transition, this statement seems to be a great oversimplification. Bowlby describes three phases of mourning,[6] similar to those suggested by Tyhurst.

The first or the impact phase of mourning can take from one day to one month or six months or more. The bereaved has a sense of being lost and not knowing what to do next. He feels suspended from life, there is an inability to concentrate and an indifference to his immediate needs. The stress seems to come from the fact of the death itself, the need to realize that it has really occurred, in the face of a tendency to deny it; there is further stress in that the world has not stopped and life goes on. His time perspective excludes a future; he lives in the here-and-now, which has no meaning to him. He cannot believe that life will ever be worth living again.

The first task during this period is to arrange for the funeral. There is an immediate need to determine the survivors' financial state. The bereaved's confusion and numbness may hinder his ability to deal with these chores. Someone else may have to attend to the details of the funeral and the needs of the family, particularly where there are dependent children. The impact stage may be the time when the bereaved has the most learning to do in terms of the new reality that impinges on him. It may be the period when he is least able to do so. Lindemann observed that during this period people reported a sense of unreality, a feeling of increased emotional distance from other people, and an intense preoccupation with the image of the deceased. They also experienced their own hostility (toward the deceased). These feelings surprised the mourner, are inexplicable, and they are sometimes misinterpreted as signs of approaching insanity.[7]

The second phase, the recoil period, is not always clearly differ-

[5] John Bowlby, "Processes of Mourning," *International Journal of Psychoanalysis,* XLII (1961), 329.

[6] *Ibid.,* pp. 317–30.

[7] See Erich Lindemann, M.D., "Symptomatology and Management of Acute Grief," *American Journal of Psychiatry,* CI (1944), 142.

entiated from the first phase. It can extend from one month to one year or even longer after the death. During the early part of this period, family and friends return to their customary roles, and relationships with them become more nearly what they were before the bereavement. In some instances this leaves a vacuum, if they had provided a good deal of support and aid. Their support appears to be needed less, since the bereaved person usually begins to emerge from the fog, begins to take charge of himself and his family again, and at least superficially appears to be carrying on. The concrete tasks that need doing are related to maintaining a household. Some women may consider becoming breadwinner as well as homemaker. A man with dependent children may need a homemaker, or he may move in with relatives. The stress seems to come from an awareness that the deceased is gone and from the necessity of assuming a new role for which he has no experience. The psychological tasks are more subtle as the widowed individual moves ahead. This is when he reports experiencing the loss most acutely because the numbness has lifted and the ability to feel has returned. Some persons report going through a period of trying to do things exactly as the deceased would have liked, as though trying to recapture him in spirit if not in fact. Their time perspective is primarily in the past. A need to talk about the deceased and to review the details of his death can become an obsession, to the annoyance of friends and relatives. Anger and sometimes irrational feelings about the tricks life has played may be expressed with great intensity, sometimes more frightening to the audience than to the widowed person himself, but nonetheless frightening. This is the time when a widowed person experiences acute periods of loneliness, and even when he is with people there is no relief. The widowed also report that they begin to move away from their married friends, resenting their sympathy; they begin to feel like a fifth wheel, that they are different, "defective," since they are no longer part of a couple. It may be easy to remain at this stage. While the individual may make an adjustment which permits him to carry on, his activities may be more related to his past than to a future in which he has given up the deceased as a central person in his life.

Parkes and others have identified certain patterns which they

suggest may lead to mental illness. The syndromes of chronic grief and of delayed grief may become apparent during this period. It may be that the symptoms of the impact phase last into the second period, or perhaps do not develop until the second period. Parkes describes a chronic grief syndrome as,

> an abnormal prolongation and intensification of the typical forms [of grief] frequently associated with ideas of guilt, self-blame, hypochondriacal symptoms resembling the deceased's last illness, and a regressive or delinquent behavior. Delayed grief is a form in which a typical or chronic reaction takes place after a period of delay, which may range from weeks to years in duration. Distorted forms may occur during the period of delay, but there is no reason to regard them as peculiar to this form of grief.[8]

The last stage, the period of recovery, a time of looking to the future, can occur within three months to two years after the death. The tasks involve letting go of the past and building a new life. This means learning to be alone, finding a meaningful social and emotional life, in addition to being head of the household, breadwinner, and both mother and father where there are children. This is the hardest period to describe. Whatever adjustment any given individual may make will depend on his life style, education, personality, and so forth. In fact, we know least about this period. Most of the psychiatric literature and reported experiences are concerned with the person who does not make an adjustment.

Is it more important to relate to the phase of the transition the bereaved person is in rather than to the symptom of depression? The depression may be an appropriate response, considering the time and nature of the stress. In addition, since the work of transition also involves a role transition, a good deal of social learning must take place as a result, and the individual's ability to learn, and the need to learn will depend in part on what stage he has reached in the transition and also on other factors in the social system in which he lives. Marris points out how the realities of the widow's life can interfere with her efforts to make a new adjustment. He is talking in the context of the British social welfare sys-

[8] C. M. Parkes, "Bereavement and Mental Illness, Part 2. A Classification of Bereavement Reactions," *British Journal of Medical Psychology*, XXXIII, No. 1• (1965), 14–15.

tem and points to the impact that financial stress has on the individual's ability to deal with this new situation:

> Social insurance could do much to soften the stress of widowhood, poverty accentuates all the more the tendencies of grief, the isolation, bitterness, apathy, the sense of being rejected, a drag on the happiness of others. While to secure a comfortable standard would instead at least encourage her to master them. Freed from the fear of financial dependence she would be less diffident in her family relationships.[9]

Marris also notes that it may be six months or more before the individual is ready emotionally to take hold of the situation. This is part of the work that he has to do in phase two, which is to come to grips with the reality of his new life. Marris reports that even up to one and two years after their husband's death, "widows still felt isolated in a struggle they could not share," and

> While they found much support and companionship amongst their family, they still felt lonely and apathetic towards social life. They tended to feel awkward in company, resentful of any hint of pity or patronage.[10]

When we think of bereavement, then, we do not think only of the individual's grief and mourning, but also of the new context in which he must learn to live. How much the bereaved is able to do for himself and how much he may depend on others to do for him or with him, will depend on the stage of mourning. To deal with these problems in terms of the individual's past adjustment will not be as effective as dealing with them as a stage in the transition which he will experience and which with time and mastery of the current situation he will be able to cope. It might be more important to examine the resources that are available to help the bereaved cope with the new demands being made on them.

To find out how the needs of the widowed are met, I inquired into the services available to them through the health and welfare agencies, the psychiatric clinics, and the social service departments of general and chronic disease hospitals in Boston. None of them serve the bereaved as a special group. I then turned to whatever other resources might possibly offer some special service. These

[9] P. Marris, *Widows and Their Families* (London: Routledge & Kegan Paul, 1958), p. 129.

[10] *Ibid.*, p. 85.

ranged from the undertaker, to the group worker in a settlement house, to members of widows' and widowers' clubs. I also learned of a cemetery office in a near-by community which offers a family guidance and referral service staffed by a widow. This woman gets in touch with all the families of people who are buried in the cemetery, with special attention to the younger widowed person, so that if they have specific problems they will know where to go in the community.

My inquiry led me to study self-help groups. We knew from knowledge of the Cruse Club for Widows in England that this kind of organization can be most effective in helping widows recover from their loss. (The groups in this country are for both widows and widowers.) As Maddison has found, another widowed person is often the most helpful during the critical period.[11]

Most social and psychiatric agencies reported that while they did not offer special services to the widowed, they did try to help those who came to them, depending on the type of difficulty and the agency involved. Their services were directed toward problems rather than toward groups in critical transition.

Maddison found that widows do not use agencies. Family, friends, physicians, and other widowed people were the ones to whom these women regularly turned for aid. In order to learn what problems were brought to the agencies by the widowed people who used them, I screened the intake of all psychiatric and family agencies serving one community in Boston. In addition a telephone survey was conducted to find out what their potential clients might know about community resources and where they did turn. I called all people under sixty, who had been widowed for a year and who had a telephone. (This community has a population of 200,000 and is ethnically and racially heterogeneous: about 250 people under age sixty are widowed each year.)

There are many services that could be of use to the widowed person, if he knew of their existence and if he could appropriately assess his situation in order to match his problem with the program offered by the agency. I examined the services available in

[11] D. Maddison and W. L. Walker, "The Sequelae of Conjugal Bereavement" (1966; mimeographed, to be published).

terms of the phase of bereavement an individual might be undergoing and projected where he might go and what he might do. Initially, of course, the undertaker and the clergyman are always involved. Family and friends may keep the household going. The outsiders most likely to be called upon for help are lawyers, physicians, and clergymen. Applications for Social Security and public welfare follow a routine pattern, and these governmental agencies are the only agencies likely to be involved automatically with large segments of a widowed population.

If the family belongs to a settlement house or a group work agency, that organization may provide baby-sitters, financial guidance, counseling, and so forth. These are the only agencies that offer a multitude of services, as well as early visits in the home to determine how they can be most helpful. Family Service can provide homemaker service. Family Service and the psychiatric clinics are prepared to give counseling if the bereaved applies. (When the mourner is confused and numb, with little hope for the future, he is unlikely to apply for casework services; if he does, he probably does not hear a word that anyone says to him.)

Generally, the bereaved has to make his own way to the various social agencies that may be able to help him. The problem becomes even more critical in the second phase when the bereaved is ready to reach out and begin to reorganize his life. Vocational counseling, guidance, and retraining for employment are available through the State Employment Office. The Massachusetts Women's Educational and Industrial Union provides counseling and job placement for women who want to return to work. They also train and place permanent homemakers—especially important for men who want to keep their families together. The clinics and family service agencies provide counseling. The group work agencies have clubs and educational programs for various family members. The Big Brother and Big Sister organizations provide surrogate parental figures. If an individual needed help to secure a job or someone to talk to about his grief and loneliness or a homemaker for his household, and if he knew about all the agencies, he would have to be an administrator to coordinate the various services he required.

An agency executive described the problem which is created for the client and for the agency by the current specialization and subsequent fragmentation of services:

> We see a mother and her son about assigning a big brother to her boy. Mother has many problems which she begins to tell us about. She develops a relationship with our worker around the big brother assignment and she wants to go on talking to the worker. This is not a casework agency. If we try to make a referral, this mother will not follow through, and the opportunity to provide some help around her own adjustment and needs is lost. We've decided to set up groups for these women and work with them as we can when they will not accept a referral. We are being criticized by the casework agency for stepping outside of area of our prescribed jurisdiction. What to do? We decided that the client comes first, and we will see what happens in time.

In the third phase, recovery, the same services are available if the widowed individual wishes to make long-range career plans, find a permanent homemaker, and so forth.

Do the widowed avail themselves of these services?

I have screened the intake of Family Service, Catholic Family Counseling, Jewish Family Service, Community Child Guidance Clinic, Community Adult Psychiatric Clinic, State Hospital In-Patient and Home-Treatment Service. From January through April of 1966, the family agencies received no applications for casework from widowed people. They had four applications for homemaker services, three of which were for temporary help because in each case a widowed mother was prevented by physical illness from caring for her children. The fourth application was less straightforward. A family was challenging the father's adequacy to care for his children and the relatives wanted a homemaker so that the children could live with them. We would want to know more about the mothers' illnesses in view of the finding that younger women have a high risk of becoming physically ill within the first year after their spouses death. The agencies did not associate the call for help with the bereavement nor did they think they were directly related.

The psychiatric services, both in-patient and out-, received nine calls for help. One woman called Home Treatment after her discharge from the hospital, so that only eight people were involved

—seven women and one man. Five of the women had diagnoses of depression, one had a chronic brain syndrome as a result of alcoholism, and the seventh was a chronic schizophrenic. The widower, whose child was a patient of the Child Guidance Clinic, was a primitive type who seemed overwhelmed by his need to be both mother and father. In all but one case, that of a woman whose husband died sixteen years ago, the call for help could be traced to the death of the spouse. In two instances the women had chronic psychiatric disabilities but were managing without help until their husbands died. Another woman had had treatment several years before and came for help shortly after her husband died. The women reported that they were unable to work, and therefore unable to support themselves. In two cases, one noted at the Child Guidance Clinic and one at the state hospital, there was a gradual deterioration of the family after the death of the spouse. In the former, the school referred the adolescent girl for help. The father felt unable to deal with the children since his wife's death. Two years before he had been referred to Family Service because his older daughter was caught stealing. There was no woman with whom the girls could identify. In the latter case, nine out of a family of ten children were in placement. Their mother drank when under pressure and was first hospitalized two years after her husband died from alcoholism. The pattern seems to be that if a woman has had no psychiatric treatment *before* her spouse's death, her call for help is likely to come about two years following his death. We get an appreciation of how complex the bereaved's problems are and that psychiatric services only briefly touch one aspect of them.

The telephone survey designed to get the bereaved's view of agencies reached nineteen people out of a potential fifty-eight. Thirty-six could not be reached because neither they nor the deceased was listed. Nineteen of the remaining twenty-two were willing to answer my questions about what services they knew of in their community. This population does not represent a cross section of the community. For example, about 10 percent of the community is Jewish, but 25 percent of the population surveyed is Jewish. Of the people who do not have phones, most are Catholic.

From a statistical point of view, these findings have little meaning, but they are useful for learning something about the attitudes of a particular segment of the population.

There were ten women and nine men in the sample. Five of the women did not work, four were receiving Social Security checks because they had dependent children, and the fifth was emotionally disabled. Of the five women working, four were already employed when their husbands died and the fifth found a job to support herself after he died. Two of the men had dependent children. In one instance the youngest was twelve and there were older siblings to manage the house from 7 A.M. to 5:30 P.M. while the father worked.

Grown children were most helpful at time of death; others reported that friends and family were wonderful. One person mentioned a family doctor as being most helpful; another, a relative new-comer to the community with no family here and few friends, mentioned the social worker in the hospital. One woman with five children who was dispossessed from public housing for nonpayment of rent prior to her husband's death felt that no one had been helpful. Another widow reported that she had a very nice family, but that they were all married and had their own problems.

Eight people said if they had serious difficulties and did not know what to do, they would see their clergyman; depending on the problem, however, most people projected they would talk to friends or family. However, during the past year neither clergy nor family doctors were seen as helpful. One woman's doctor told her to stop feeling sorry for herself. Four people were receiving medical attention for heart conditions, arthritis, and so forth. Three of these suffered from these ailments prior to the bereavement, and there has been no change in their condition. They felt that they were able to withstand the crisis of bereavement in spite of their illness. One woman with a serious heart condition said, "I turned to steel when it happened, so doctor wasn't worried I'd get sick."

What agencies are these people currently using? Four respondents receive benefits from Social Security, and two of them who have very limited financial resources receive additional support

from the Veterans Administration and from welfare respectively. One of the nineteen has an emotional illness and is being treated at a general hospital out-patient psychiatric clinic. The four who receive Social Security do not consider Social Security an agency and do not feel that in collecting their benefits they are "receiving help." The widow who was a patient of a psychiatric clinic was referred there by a family agency which she consulted shortly after her husband died; she had gone to them many years before when her boy dropped out of school. She reported to me that she cannot concentrate, cannot work, and depends on her son to support her.

These people, then, do not use agencies. In their words: "I just carried on"; "I didn't know of any service so I just solved the problem myself—I found the nursery school in the phone book"; "We lived together for thirty years and we got ourselves through the dangerous times." If they needed money, they would borrow from the bank or go to their family. They knew of welfare from the newspapers or from experience during the depression. One man recalled that he thought it was Family Service that provided his daughter with braces after she had polio.

They all knew there was a large state hospital in their community. One respondent's wife had died there, but none of them knew about the other psychiatric services, such as the adult and child guidance clinics. Several respondents said they would go to the State Employment Service if they were seeking work. Generally, they would look in newspapers, see friends, or go to a private agency. One woman on Social Security knew about the Manpower Training and Development Act. She planned to apply when her youngster got older, and she also thought of getting him a Big Brother in a few years, since he missed his father very much. She also knew of a psychiatric service at a a general hospital where her oldest boy had been helped. She had spoken to the social worker and felt that she would go there if she ever needed that kind of help (which she saw no need for now). She was the only respondent who talked this way, and she thought talking might help lead her in the right direction. She knew the hospital would not give advice. Another respondent had thought of going for help because of her loneliness. She rejected the idea, since she could not see

what good it would do to talk to someone who did not really understand what she had been through. Her advice for what would be most helpful to widows consisted of the following:

> Like to meet a male who is lonely, gone through kind of life I have, who I could make happy, someone do good for. Unless get fixed up, no place to go. I'm not the type to go seeking; a few younger widows do go to Parents without Partners. Isn't one under seventy who doesn't want to go to bed with you. I have loads of friends, but I'd like male companionship, someone to be a friend to.

So far as their current situation is concerned, five feel that everything is fine, they are managing to carry on; four people are suffering from chronic physical illness, and one of these has financial problems. She is still paying bills incurred at the time of her husband's death. Another, who is ill with a heart condition, complains that she is lonesome and that it is hard to get over the fact that her husband is dead. Three other people spoke of being lonesome; one man said that he had no one to talk to so he talked to himself. Another woman feels little consolation from her family's attempts to cheer her up. One man is just recovering from major surgery, and his daughter is staying home from work to care for him. Three people have problems relating to their children; ranging from needing a baby-sitter to having a boy in jail for car theft. This latter mother has five children and is looking for another place to live. The woman with the psychiatric problem is worried about whether the family will pay for her husband's unveiling (dedication of the tombstone).

In summary, it seems that one year after the spouse's death, most of these families are still experiencing many problems related to the spouse's death and to their new status. They did not seek outside help, nor did it seem to them that psychiatric or casework services had any relevance for ameliorating their difficulties. As independent people they felt they had to deal with their problems themselves.

What aid might be helpful and most useful? The self-help groups offer some interesting suggestions in this direction. These groups have developed under various sponsorships. The local Catholic archdiocese sponsors groups in Washington and Chicago,

Post Cana and Naim Conference, respectively. They Help Others (THEO) in Pittsburgh is an independent group, as is the Widows and Widowers Club that meets in a suburb of Boston. Community centers sponsor single-parent groups. Probably the best known independent group for single parents is Parents without Partners, whose membership consists of divorced and separated people as well as the widowed.

In my conversations with widows and widowers who are members of these groups, I learned that most people do not join such organizations until they are well into the second stage of their bereavement. The opportunity to join, to find people struggling with similar problems, and to make new friends is acutely needed when they become bored with their current situation, look for new directions, and flounder in their efforts to build a meaningful life alone. The self-help groups serve several functions. For one, they seem able to help the individual learn a new social role so that he can reach out again and find a place for himself in a circle of friends without feeling "defective" and like a fifth wheel.

This is a crucial transition, since it seems as if real recovery may hinge on the individual's being able to make a new social life. For example, one young widower pointed out that he felt guilty if he went out and left the children, and he had forgotten how to date, how to go out with a woman without getting too quickly and inappropriately involved. As a result of his social isolation (he was not comfortable going out with his married friends), he was developing a second-line depression. He found himself hovering over the children, and eighteen months after his wife died they were the center of his social life, which he felt was not good for them or him.

Although the programs of these clubs vary, basically there is a good deal of similarity. In addition to social gatherings, such as dances, there are discussions about the problems of the widowed, activities for parents and children, and mutual-help groups. An example of the latter is a helping hands group whose male members are available to help women who own their homes when something goes wrong with the plumbing and the like.

Self-help organizations, such as Alcoholics Anonymous, have a

long tradition of succeeding where professionals have failed. To my mind, there are similarities between their activities and those of the indigenous nonprofessional workers who are helping specific groups of clients whom the professionals have had difficulty reaching. It is not yet clear to me how to account for this success. Can social workers learn something from them about ways to be more helpful with a particular population of people in need or at risk? Will we also learn that there are many people in serious need who are not served best by us at all?

We have institutionalized the helping process so that services are offered in an impersonal and stylized manner. The client enters the system in a specified way which locks him into a subordinate relationship to the social worker. The very act of asking for help involves a dependency and puts the potential recipient in a subordinate relationship to the expert who he hopes may know how to relieve his pain.

Vinter describes the impact of bureaucratization of organizational structure on the way that services are delivered. The individual professional, he writes, is often in conflict with the goals and procedures of the agency.[12] As a professional, his goals are to serve the individual as needs arise. The agency structure dictates what needs he may serve and how he may do this. It seems to me that in casework we have developed a professional ideology which minimizes the conflict. We accept the agency structure with the justification that it is of value to circumscribe the involvement we can have with our clients. The office setting provides a certain impersonal environment in which the therapist can control the transference-countertransference which we see as the basis for helping the client understand himself. An impersonal aloofness seems to be a logical consequence of this kind of ideology and organization. This can prevent us from having a real encounter with a client at a point when he needs this most.

If the client has no wish to define himself as a problem, no wish

[12] Robert D. Vinter, "The Social Structure of Service," in Alfred J. Kahn, ed., *Issues in American Social Work* (New York: Columbia University Press, 1959), pp. 242–69.

to assume a dependent relationship with a "stranger," he may not choose to seek help no matter how great his pain. Furthermore, by the time he finds out about the service, makes an appointment, and gets through intake, he may have resolved his problem, found other resources, developed new ones, or the problem may have reached a point where it can no longer be appropriately helped by this particular service. In the light of this analysis perhaps I should modify my opening sentence to say that it is amazing that we *do* see clients in crisis, so far removed are we from their lives and problems. If we see ourselves as offering meaningful services to people during critical transitions, do we have to consider new ways of delivering our products to the consumer? As professionals we guard our right to intervene and to plan for services. We sometimes act as if we have a monopoly on helping people with problems of personal adjustment. Is a nonprofessional, such as another widow, a more appropriate source of help?

I am not prepared at this time to state definitively the implications of the preceding analysis for casework practice. Looking at bereavement as a critical transition, my first attempt at service would be to help the mourner move from one phase to the next. This would mean, first, finding a way of reaching out to him; it would also mean being able to provide or make available a range of services to help deal with the new realities that impinge on him. The younger widow and widower are a population at risk. By expanding the resources available to help them cope with the various stages of mourning, we may be able to prevent the development of chronic grief syndromes, social isolation, and so forth. We receive requests for help from people whom we diagnose as suffering from pathological reactions. I prefer to understand this as a fixation at the impact or recoil phase of the transition period rather than as psychopathology. The goal of treatment would be to help them move to the next phase. Casework services would only meet a segment of the problem, which includes the need to talk, to review the circumstances of the death, and to try to recover the deceased in fantasy if not in fact.

It seems to me that the entire approach leads to prevention once

problems are viewed as stages in a critical transition. We hope to prevent a fixation at one stage from becoming a chronic maladaptive mode of behavior.

Primary prevention would occur at an early point in the critical transition. The service should be available immediately, or certainly soon after the critical event occurs, and it should reach every exposed person in the population at risk. Unlike our colleagues in public health, we do not have a mandate to reach out to every member of a population at risk, unless they request our service. In addition, as caseworkers what kind of immunization can we offer? I have experimented with ways of trying to get around this problem in order to provide preventive intervention with the widowed at the earliest possible moment. My informants report that even where death is anticipated, "grief work" cannot be circumvented. At least it is possible to plan for the funeral and to provide for the family, thus limiting the number of stressful realities that must be dealt with. Looking back on their own experience, they feel that the critical time to intervene is at the end of the first month. A clergyman often can be helpful at this point, while a social worker or a psychiatrist would be suspect and turned away. Another widow, who is also a neighbor, is always welcome, and her interest and concern would be considered legitimate.

The Laboratory has recruited as collaborators in a projected program for early intervention a Catholic women's organization which crosses parish lines, a synagogue which serves most of the Jewish residents in the defined community, and a YMCA which serves the Protestant community. Together we will sponsor a service in a given community staffed by widows who represent the various religious and racial groups. Working from their homes they will call on every new widow and widower under sixty years of age within one month after their bereavement. These workers will receive some orientation about human behavior and about available resources. The helping techniques they develop will come from their own experience and their assessment of the problem. They can also serve as bridges to, and coordinators of, various agency services. The service will be confined to one community, thus allowing us to reach all people in the target population, per-

mitting the bereaved easy access to one another and to the worker, who will indeed be a neighbor and one whose activities are legitimated by their sponsorship by agencies which are considered appropriate sources of help at the time of a life crisis.

Group Services in Therapeutic Communities

by LESLIE J. SHELLHASE

THE CONCEPT OF COMMUNITY has its origins in the dim and unrecorded past. At his most primitive man has repeatedly found the advantage of his participation in, and identity with, his fellow man in the structure and experience of community. Truly, the account of mankind is recorded within the context of community. Man has most effectively been able to advance himself and to help his fellow man within his community experience.

The history of man's response to mental illness, even in its primitive phases of demonology and banishment, has always shown evidence of his sense of social responsibility. Even in those dark chapters of history when the mentally ill were denied full human membership, there were forces which sought to conserve and defend the community.

The growth of humanitarianism in the mental health movement is the locus from which the concept of community has developed within mental hospitals. The traditional dichotomized human organization that was the usual mental hospital in times past partook but little of the human resources that are generated through the community experience. This arrangement, wherein one group of people, the staff, took care of and ordered the existence of a second group, the patients, attended closely to the maintenance of boundaries between the two groups. This was true not only functionally, but also sentimentally.

It is the relinquishment of these boundaries that characterizes the development of the therapeutic community. Just as it had

taken deliberation and ongoing confirmation to maintain such boundaries between staff and patient, so also it requires concurrence and continued reaffirmation to maintain the absence of boundaries within the therapeutic community. In the past, role differentiation between staff and patient was along an axis of activity and passivity. Within the therapeutic community, this simple model is no longer of value. There is a necessary demand for active engagement in the affairs of the community by staff and patient alike.

In the past, also, authority was located within the staff element of a hospital. To the extent that authority was a dynamic element in the healing process, it was regarded as effective only within the possession of the staff. Even within the staff, authority was carefully delineated and controlled among its several echelons, so that the possession and exercise of authority were determined in a hierarchical fashion. Within the therapeutic community, one finds a departure from this structure. One finds staff not abandoning authority but rather seeking, inventively, ways in which authority can be shared with the patient. The modes in which this goal has been achieved have been numerous. The blurring of lines of authority, the involvement of the patients in decision-making processes, have brought about many changes in the transactional structure of the mental hospital. One of these changes has been that there is left no acceptable role in which an individual may remain disengaged from the communal processes of the hospital. No one is allowed to deny the relevance to himself of the community and its goals. Just as the patient is continually confronted with the necessity of his involvement in the purposes of the community, so also it is no longer possible for a staff member to be so disengaged from these purposes that he mechanically can discharge his obligations to the hospital. Neither is it possible for a staff member to subvert his position and authority so as to serve his own ends. This is no longer possible through subterfuge, but, paradoxically, it can be accomplished in an overt and approved fashion.

If a therapeutic community is based upon a common identity rather than upon a rigidly maintained compartmentalization of those in need and those with resources, then, with this common

identity comes a common and mutual claim upon each other by those within the community. Just as there is recognition that the troubled individual is the possessor of both need and resource, there is recognition that this circumstance is descriptive of the staff person, as, indeed, it is descriptive of mankind generally.

This common identity is at the heart of the entire notion of the therapeutic community. The challenge made to the helping person remains despite the shift from traditional treatment modalities to the therapeutic community. It remains for the staff person to create the occasions wherein goals are reexamined by groups and individuals within the community. There is a basic and essential entry into a process of socialization.

The process by which the staff and patients of a hospital go about constructing and then maintaining a therapeutic community is a complex one. The very notion that the needs of the patient can be best met through a community approach demands types of behavior and commitment from the participants for which they have had little specific preparation. Perhaps the most central preparation is on the part of the staff. It is necessary that they view themselves as something more than specialists in behavior. The staff members must consciously engage themselves as representatives of the larger society within which the therapeutic community is located. The end toward which the endeavors of the therapeutic community are directed is the successful reentry of the troubled person into the affairs of this larger world. It is vital that this link to the larger world be maintained at all times. This is the central criterion against which all therapeutic ventures must be cast: Does the patient's experience within the therapeutic community prepare him maximally for participation in the larger society?

This requirement has the meaning, then, that the patient is never allowed the orientation that the hospital is a sanctuary providing him immunity from the larger world. A commonly defined reality governs life both within and beyond the therapeutic community. Rather than sanctuary, the troubled person is confronted with the necessity of maintaining himself in communication with the world around him. The distinction of the hospital as a therapeutic community is that it is a place where the faltering individ-

ual is assured of the support and concern of others in his successful mastery of the fears and disorders which have earlier kept him from full and rewarding engagement in the affairs of the world around him.

The distinct contribution of social work to the neuropsychiatric interdisciplinary team has always been centrally that of social functioning. Social work has always concerned itself with the relationship that exists between the client and his environing society. To a major extent, social work has regarded the adaptive difficulties of the client as being related to a faulty response to the normal social controls within the client's life situation. The goal of social work in bringing about a rapprochement between the individual and his community involves not only an extension of the social skills of the troubled person. It also involves an analysis of the significant dimensions of the social environment and, when indicated, a redefinition of the demands of that environment upon its members.

To the extent that social work has always been concerned with the interaction between the individual and his social environment, the rise of the therapeutic community has provided the social worker with the opportunity to contribute in an extended fashion to the functioning of the psychiatric team. The basic concepts of social work view the client within his social situation. These concepts also provide the basis for the helping relationship between the social worker and the client. These concepts present a philosophical base for the nature of man in its significant dimensions as they related to the interests of social work. These ideas, detailing the nature of man as one of inherent dignity and demanding of autonomy, contribute centrally to the construction of a therapeutic community.

The alteration of the helping process within a therapeutic community, wherein the lines of distinction between helper and helped are blurred, demands a different order of controls than was needed in traditional therapeutic settings. A major shift in focus is demanded of all participants in such a community. The most drastic shift must be made by the client himself. This is particularly true as he must extend his range of concerns outward beyond him-

self. For the psychiatric patient, who has frequently had social experience of a poor quality and who has been poorly joined, at best, to a number of potentially socializing experiences, the needs for guidance and support are heightened. Only by this attention can he begin a process which will call for the development and exercise of new social skills.

One of the distinct contributions to be made by the social worker derives from the nature of his disciplined self-awareness within a wide range of human transactions. He is able to provide guidance to the other disciplines within the therapeutic community because of his sensitivity to the exchanges that occur among the people within that community. Within the area of social transaction, the social worker is especially attuned to identifying the existence of need. He is also able to mobilize response to such need, not only from his own resources, but more especially from a wide range of social resources within the community. In this, he joins in purpose with all members of the community, staff and patients alike. The social worker contributes to the creation and maintenance of a social environment wherein each member becomes convinced of the mutual claim upon each other that characterizes the therapeutic community. This claim is operative in regard to both the affections and the resources of each individual within the community.

While there is a blurring of the distinctions between patient and staff within the therapeutic community, there remains a demand that is made exclusively upon the staff person. This is the demand that, even in the therapeutic community, supremacy be given to the needs of the client. This requires a disciplined self-awareness on the part of the helping person that is even more demanding than the comparable requirement in the established therapeutic modalities. Within the therapeutic community, the range of acceptable behaviors is much more extensive than in other types of treatment. In part, this condition is a derivative of the nature of the community, wherein there is a considerable shift from the caste and class system of the hospital. This wider range of behaviors brings both patient and staff member into a greater complexity of relationships. Unlike earlier therapies, in which

there was a well-defined area within which therapeutic relationships could be developed, the range of relationships now spreads over the matrix of human relationships to be found within the enviroining society.

A striking change is that the helping person is no longer the sole determiner of the external reality to which a therapeutic situation may be joined. External reality becomes more nearly a consensually perceived situation shared by both staff member and patient. Further, this reality is affirmed by numbers of both staff and patients. The ability to say what is real within the therapeutic situation becomes less the property of an individual therapist and more the property of the situation within which staff and patients find themselves. This does not, however, mean the triumph, through numbers or persistence, of the pathological perception of a patient over a commonly defined and accepted reality. Rather, the patient and the staff person, as members of a single community, must achieve and maintain a consensus as to the realistic dimensions of their own experience.

It may be assumed that every existing therapeutic community is in a continuous process of innovation. Since the ultimate purpose in such an endeavor is to strengthen the relevance between the individual and his society, the limits are those of the society itself. To speak of broader application of the principles and processes of the therapeutic community is paradoxical, since it suggests that the model of community, from which the therapeutic community was drawn, could, in turn, be enriched from that specialized development. Yet, it is in the very nature of the economy of human experience that there is return to the giver, that borrowing implicitly contains return. So it is that the conscious and deliberate exploitation of group and community forces in the therapeutic community suggests innovations to be applied elsewhere.

Particularly in any closed institution does one find extended endeavors to strengthen the relevance between the internal structure and processes of that institution and the larger society. Since the goal of most such institutions, such as hospitals, prisons, and child-care units, is the adequate preparation of its clientele for living in the larger world, this relevance is understandable. This is in con-

trast to earlier orientations in which the closed institution may have viewed itself as a specialized segment of the larger society designated to contain and hold those demonstrably incapable of maintaining themselves in the larger society.

The advance of the therapeutic community as a means of relating resource to need in regard to the mentally ill has been paralleled by similar advances in the correctional area. In a number of instances, correctional institutions have not only reorganized themselves so as to approximate more nearly the dimensions of the larger society, they have also successfully asserted themselves as elements of that larger society. The focus of modern correctional endeavors is on equipping the offender with a more accurate assessment of the demands of the larger society and with the skills requisite for an adequate response to these demands.

Perhaps the most far-reaching development stemming from the philosophical and procedural bases which have developed the therapeutic community is the rise of the community mental health movement. A forerunner of this movement was the development of command consultation within the Army. This latter program was based upon the conviction of the self-sufficiency of the company-sized unit in the Army. Whenever an individual found that his own personal resources were not adequate to current demands upon him, most frequently he would depend upon the resources of those upon whom he had the most immediate claim, the fellow members of his own unit. It was only occasionally that a need might arise that could not be met by resources within the unit. Upon occasion, the resource provided by a fellow member also provided reaffirmation of the claim of the troubled individual upon the common body of sentiment that was central to the experience of a unit.

Within the continued development of the mental hygiene movement it was found that frequently an individual was sent outside the unit when the most ready source of help was available within the unit. For example, a soldier sent for help with adjustment difficulties might ask; "Why can't I find a place for myself in the unit? What am I doing wrong?" Obviously, these questions could be more profitably addressed to his colleagues who know

very well what he is doing wrong and what corrective measures need to be taken. It is much less effective for him to be sent to an outside specialist to raise these questions. To provide an answer, the specialist has to go to the unit, the community, to determine what has to be corrected. His participation, or intervention, if you will, creates the occasion and necessity for the members of the unit to consider what they are willing to do to help the troubled individual to join the unit. Frequently, there is a clarification of the position of the troubled member. Communication may be cleared so that his sentiments toward the unit are viewed as both positive and acceptable to the other members. There is then created a more promising and feasible opportunity for him to join fully in purpose and identity with his unit.

In this example, success does not depend upon the creation of social skill by the social worker. Rather he calls forth the skills already in existence within the unit. The process by which a new member is taken into the group is not invented by the social worker. This process is in the very fabric of a group's existence and has its origins in the cumulative group experiences of its members.

In its broadest sense, any community can become a therapeutic community without altering its present purpose or goal. Basically, it becomes therapeutic in nature as soon as it begins to reduce the lack of "fit" that may exist between the community and any of its members. The alternative to such a procedure would be for a community to extrude those members whose "fit" is not commonly regarded as acceptable. While such extrusion is a natural and universal group phenomenon, frequent evidence can often be found of a group or community making considerable effort to continue to encompass such a "misfit" within the purposes and procedures of the community. Herein is a basic strength of any community endeavor that seeks the conservation of human resources—the will to make room for a wider range of behavior is more frequently present in communities than it is absent.

To the extent that a community makes allowance for individual differences among its members, that community possesses some therapeutic potential. The goal of such latitude is the ultimate binding of the concerned individual to the purposes and identity

of the community. The return to the community derives from the contribution to be realized from the allegiance of its individual member, whereby he makes available to the community a measure of his energies, his personal resources, and his sentiments. The cumulative effect of such allegiance contributes to the strength of the community.

Perhaps the ultimate role of the social worker in any community endeavor shall remain that of the consultant. He limits himself when he becomes central to the concerns and deliberations of any specific group. When the worker enters into the processes of autonomy and self-direction of a group, he has compromised his helping role. His central effectiveness to a community is to be found in his ability to help that community to clarify the nature of its needs and to mobilize and allocate the resources required to meet those needs. The return to the social worker, then, is not membership in those groups which mean so much to him. Rather, his reward comes from the sure knowledge that his efforts in behalf of a group have enabled that group to fare more certainly in the future without his direct intervention.

The central values held by social work have derived from the enduring values of human experience. The necessity that human exchange recognize and further the inherent dignity of man and his quest for self-fulfillment is basic to the orientation of social work. As a contributor to any human endeavor, social work provides some insistence that this view of man be maintained. Social work aids in the maintenance of this goal through all the variations that are to be found within the range of human experience. So long as social work continues to achieve a resonant response from the community it serves, it may be assured that its direction is necessary and true.

Nonprofessional Personnel in Community Mental Health

by ROSE WHEELER

MANY OF US in the social welfare and mental health fields are examining our professional and personal consciences to determine what our place is in this transitional or revolutionary period in social work and psychiatry. We are studying our long-held convictions about the causes and treatment of social problems and mental illness, and we are questioning some of these. We are especially concerned with our notions about that segment of our society that we have variously labeled "the hard to reach," the "multiproblem families," and "the economically and culturally deprived."

If we were not already painfully aware, from our own staff vacancies, that one of the greatest problems facing the mental health professions is the manpower shortage, we have been shocked into accepting this reality by recent government reports, including those of the Joint Commission on Mental Illness and Health, Action for Mental Health (1961), and the Departmental Task Force on Social Work Education and Manpower (1965).

Many of us have given a great deal of thought to the question of how we can use our skills where they will do the most good, and what parts of our present jobs can be ably done by people who have less training, or other skills, in order to deliver the best possible service to the greatest number of people in need of it. This kind of problem is more than a question of personnel classifications and job descriptions. It takes a lot of soul searching; it represents for social workers, as for members of the other mental health disciplines, a sort of professional identity crisis.

We ask ourselves whether we are abandoning our hard-won professional status, our personnel standards, and our professional responsibility by assuming that others can do our work, no matter how well-meaning, kind, and "indigenous" they may be. It may be granted that casework and small-group work are not able to solve the great social problems (and this was never their claim). However, this does not mean that there is no longer a place for these highly developed methods in social work. This problem is ably discussed by Aleanor Merrifield.[1] In the past twelve months, at the many institutes and meetings in Chicago on community mental health and the use of nonprofessionals, this question has been raised, time and again, by seriously concerned practitioners.

There are some who "view with alarm" this conflict in our profession, in which people seem to be taking sides with such strong feeling. Some of the "pioneers" have been called professionally irresponsible, and some of the more "conservative" have been accused of impeding progress. Rather than hailing the new movement as a social revolution, some writers have suggested that it may be "another therapeutic band wagon."

To others, it seems that this kind of debate is good for the profession, and may lead to more thorough self-evaluation and constructive change, while preserving traditional values in social work. What seems to be still needed is that each of us should have a greater willingness to try methods that we have not used before, really to focus on the *needs* of people rather than on the specific service we are prepared to offer or the traditional function of the agency.

For several years the staff of the Mental Health Division of the Chicago Board of Health had been experimenting with new methods. In order to meet the pressures of our overwhelming intake, we had already incorporated several procedures which were considered innovations for an out-patient psychiatric facility. We were streamlining our intake and diagnostic processes to reduce the waiting period, and were using the diagnostic staff conference with

[1] Aleanor Merrifield, "Implications of the Poverty Program: the Caseworker's View," *Social Service Review*, XXXIX (1965), 294–99.

the psychiatrist only in selected cases. We had intake groups, therapy groups, and family group therapy. We were concerned with crisis-oriented, short-term treatment. There was flexibility in the use of the various disciplines, while at the same time we retained the traditional specialty of each. Social workers were responsible for evaluation and treatment, along with psychiatrist and psychologists, and staff members of all the disciplines were taking telephone intake calls and working with social agencies, schools, and community organizations.

Our several neighborhood centers were studying ways of reaching out to their own communities and broadening their service. However, our downtown center, which functioned primarily as an out-patient facility, was far removed geographically from the people we were attempting to serve. We questioned the effectiveness of work that was spread so thin. We realized that part of the problem was that *we* were so hard to reach.

We asked ourselves how we could adapt our casework and group work skills so as to reach larger numbers of people through education and consultation. We wondered how we could use nonprofessional or subprofessional personnel when our agency had worked so hard to achieve high standards by hiring professionally qualified workers. And, in fact, was it our individual responsibility to find the new ways?

Plagued with these doubts and dilemmas, and hoping that the agency administration would set up some special projects for us, we forgot for a while that it was in our day-to-day jobs that we would find the proving ground for testing the new ideas. We finally realized that we really had to try them out and see whether they worked—for us—and if not, why not.

And so, for myself, as for others in our staff, there had to be a personal decision to get off the "upholstered office armchair," out from behind the desk, and into the community to deliver our services where the people are who need and want them.

Since most social workers are not directly engaged in large planning programs and demonstration projects with special staff or funds, and since we are, in fact, employed as caseworkers and

group workers in jobs that are service-oriented, I believe that these concerns are widely shared.[2]

The Beethoven School Project.—This project originally developed around a group of children who were referred from the Beethoven School and out of the request of its principal for an in-service training program for his teachers. The school is located in the Robert Taylor Homes, a high-rise housing project containing over 28,000 Negroes in a narrow stretch only two miles long on Chicago's South Side. It is an understatement to say that the area has a great many social problems, all too familiar to social workers, frequently associated with overcrowding, poverty, segregation, and the lack of sound urban planning.

The Beethoven School, an unusual public elementary school, has a number of experimental programs for improving the educational experience of inner-city children, and we already had an excellent working relationship with its far-seeing principal, Theodore Lewis, and his staff. The school had been trying to find clinic resources for some of the children who were having problems of social maladjustment and underachievement in school. They realized that these youngsters represented only a fraction of those in need, or potentially in need of "some kind of help," and that resources were very limited and often ineffective. To assist the teachers in understanding and handling these children in the classroom the principal asked us to provide an in-service training program dealing with mental health concepts and the behavior problems of a number of children.

Since some of the children were from families who were receiving public assistance, we were closely involved with the staff of the Cook County Department of Public Aid office in the Taylor Homes, and they too were interested in mental health education for their staff.

We realized that both groups—the teachers and the public assistance workers—represented key people in the lives of the schoolchildren. Along with ministers, doctors, and others in the

[2] Although my sources are not specifically noted here, I wish to acknowledge the influence on my thinking of the many published books and articles on community mental health, especially those by Gerald Caplan, Eli M. Bower, Donald C. Klein, Erich Lindemann, and Frank Riessman.

community, they are the "front-line caretakers," in Erich Lindemann's terms, who in their daily work have a great deal of influence on the mental health of the people with whom they are in contact. Especially in times of crisis they have the power to "tip" a person toward health or illness, and they are in a position to observe the symptoms of emotional or mental illness in a person long before he would reach the office of a professional in the field. Whether they consider themselves competent to deal with them or not, the fact is that teachers have disturbed children in their classrooms, and that public assistance workers are every day in contact with complicated and serious human problems that will never reach an agency or clinic and that would baffle an expert if they did get to his office. Thus we accepted the fact that it was our responsibility to share our professional knowledge and to help the "caretakers" (or "caregivers") make their work more effective.

We agreed to find out whether an effective method of treating these children would be through a comprehensive approach that would reach the key people in their immediate environment in their daily lives—primarily their families, their teachers, and the public assistance workers. The school selected eight children whom they considered to be in greatest need of intervention. In these families there were forty-five children who would be affected by the eight mothers, and twenty of these were brothers and sisters in the same school. Thus we saw our program as a possible step toward prevention, which might have a favorable influence on a much larger number of children than the eight originally designated as subjects for this experiment.

The mothers were invited to a group meeting weekly with the mental health worker at the neighborhood settlement house, Firman House, located next to the school. The teachers and the welfare workers, plus the family counselor of Firman House, made up another group, with the same group worker. The amount of contact with the fathers, other family members, and school personnel was to be worked out by the mental health professional with the people concerned, and she was to be available for individual consultation with the teachers and public assistance workers on the individual children. (Since I was that mental health worker, I

shall drop the editorial "we" in favor of clarity and relate my experience.)

The first meeting of the members was an orientation-intake group meeting. They were asked to bring a list of their family members and birth dates to save time, but no extensive social histories or school reports were sought in advance of the meeting. (This was partly to allow me to test my own ability to make diagnostic judgments from the material that emerged at the intake group meetings.) While the mothers were meeting with me, the children were gathered in a waiting room with volunteers and students, who later discussed their observations with me. I also spoke briefly with each child to learn his idea of why he was there. The mothers were invited to continue as a group, for an eight-week period, and they were told about the teacher-caseworker group.

There were some fascinating developments from the point of view of group process and content and the impact of the groups on each other. It became clear that the teachers and public assistance workers knew a great deal more about children than had been credited to them. Their main concern at first was the degree to which they should become involved in individual cases as part of their regular jobs; when supported by their supervisors they were generally quite willing to take more responsibility. Communication improved between the two subgroups of teachers and public assistance workers as they dealt with their differences and worked together toward a common goal. Both subgroups began to question some of the policies of their own institutions in relation to certain school problems of the children.

Following the series of teacher-caseworker group sessions, I continued to consult with them individually, and they, in turn, increased their direct activity with the parents. I continued my contacts with the public assistance staff throughout the summer in a series of meetings in their office, in which we had informal case discussions—not for the purpose of "solving" a case, but to look at it in a different way.

It was especially meaningful to the mothers that their group worker was also meeting with the teachers and caseworkers. It re-

duced their feeling of being accused of causing their children's problems, and freed them earlier to bring in some of their own ideas. While they tried at first to use my liaison role to send messages to the other group, their own ability to communicate with them improved as their self-esteem increased. There was much discussion of the apathy and seeming indifference of parents, which covered the deep resentment and hopelessness that came out in the meetings. These mothers were among the most isolated of the families known to the school, but as they began to experience acceptance and individual self-worth in the group process, they also began to reach outside for satisfying experiences. Of the original groups, which started over a year ago, two families have moved out of the housing project, in accordance with their own goals, two mothers have gone to work, and most of the others have become active in their PTA, their housing council, civil rights groups, or church groups, with the idea of improving their own lives and the opportunities for their children. They also recruited for group work other mothers whom they wanted to help or who had not responded to the school's referral. More recently, some members of another mothers' group have become active with community leaders who are beginning to plan for a comprehensive mental health center in the area.

During the summer we set up a children's activity group at Firman House for the children of the mothers who were in my groups. (There were 19 mothers in two groups by this time, and they had a total of 101 children.) The staff for this children's activity group consisted of two "Careers in Social Work" students assigned from the Welfare Council program and four high school dropouts who were enrolled in our Division as Neighborhood Youth Corps trainees. The college students arrived first and were immediately involved in the total Center program, as subprofessional participants whose reactions to, and evaluation of, their jobs would be useful to us in determining what parts of our work could effectively be done by other than professionals. They alternated in being in charge of the children's groups, the materials, the recording, the staff-group discussions at the end of each half day, and the

assignment of individual children to staff members. When they went on "field" trips I accompanied them, but the students were in charge and made the decisions.

There were nineteen children in our summer program, although we worked with no more than ten at one time so that a great deal of individual attention was possible. These were the children who could not participate in regular summer play groups or day camps because they could not manage themselves well enough to be acceptable. They were impulse-ridden, hyperactive, annoying to other children, and inattentive. Their reported behavior included lying, stealing, daydreaming, enuresis, thumbsucking, tantrums, and soiling. All were of at least average intelligence, but a surprising number had physical handicaps or poor health histories. When I asked them at intake why they thought their mothers had brought them, their answers were: " 'Cause they think I'm crazy"; " 'Cause I'm bad"; " 'Cause I don't know how to act in school"; and "Kids mess with me and I beat 'em up." They knew why they were there.

Our guiding philosophy was that these children needed acceptance, successful experiences, and the opportunity to relate to friendly people in situations where they were accustomed to rejection. Thus the play leaders (also known as "helpers," "counselors," "the ladies," and "the girls") could be friends to the children and offer experiences that would build their self-esteem and reduce their isolation.

With this orientation the play leaders could see that they could really help these children by teaching them how to get along in the world in simple ways that are usually taken for granted as part of home training. They helped children learn how to cross the street, tie their shoes, make a purchase, take turns, and follow some rules. The activity of offering simple refreshments brought about a very interesting discussion about the meaning of food to children and to mothers. I tried to give practical suggestions about setting limits, protecting the children from harming themselves or others, and giving approval. It is difficult to teach this combination of firm control and permissiveness, but much harder to practice it. The career students accepted this pattern, from their own

backgrounds, and it was interesting to see how quickly the younger girls followed their example, although their home backgrounds were more like those of the children.

It was especially gratifying to observe how quickly the girls learned to help the children verbalize their feelings instead of acting out their demands by grabbing or pushing. When a child's feeling was obvious, the staff tried to put this into words: "You are feeling very good about finishing your picture, aren't you?"; or, "You are feeling very angry because you can't get the puzzle together, but I will help you."

The most interesting part of this work was the unique learning experience for the college students, from comfortable middle-class homes, in working with the girls from the antipoverty program. In the first meeting, the high school girls seemed distrustful, nonverbal, and detached. The college girls were at first dismayed and inclined to think the hardest part of their job would be not working with the children, but working with the high school girls. (It must be admitted that this was also the pessimistic view of some of our professional staff at that time!) However, the students entered into this phase of the project with sincerity and a feeling of responsibility for helping the Youth Corps girls in their training. They came to appreciate these girls, from an entirely different culture, as warm, lovely, interesting individuals, and as willing, capable colleagues. The two groups learned to share their knowledge and their peer interests, and they grew as they learned from one another.

We all observed that the four high school girls, whose backgrounds were similar to the children's, contributed to our program in ways that could not be equaled by any other kind of staff. The most heartening thing was that, no matter how difficult some of the children were, the girls were always ready to have them return, even when I thought it might be wiser to exclude them. The leaders were physically and verbally abused by Jane, our most extreme example, but they insisted upon inviting her back, because, as they said, they could "take it," and they felt Jane needed the experience.

Sometimes it was difficult to tolerate some of the acting out of

the high school girls, which the students correctly identified as being of the same nature as the provocative behavior of the children. For example, when they were angry they would come back late after lunch, or absent themselves for a long time in the rest room, or smoke when it was against the rules. Sometimes they would spend money for refreshments, though we asked the children not to do this (perhaps for reasons that were not made clear to them). It was difficult to get them to discuss these things, and we had to learn to "sit it out." It was gratifying to see that as the girls encouraged the children to "talk," they too expressed their own feelings and thoughts, both in spoken and in written language. Their reports were treated with respect, and they were shown the typed copies that became a part of the children's records.

Following is an example of the notes taken by one girl, a high school dropout who later returned to school:

> I tried to talk to Jane but it didn't seem to do any good. . . . I gave her crayons to play with but I still couldn't reach her. I guess it will be different after I get to know her better because I have only known her for one day. [Later] . . . Jane wasn't talking much but she told me that she would like to come back Tuesday. . . . She is a very sensitive child, and if someone will give her more of their time I think she will be a well-behaved child. She told me that she liked school and wanted to finish high school.

All the staff at Firman House became interested in our children and our play leaders and gave them individual attention. These included the maintenance staff, the receptionist, the home economist, the preschool teachers, and the gardeners. These people continued to be the children's friends after the play leaders completed their summer assignments. Another important "caretaker" was the corner policeman, who took the children and the play leaders on a visit to the police station. Later he came to their farewell party; he also attended one of the mothers' group meetings to clarify what the children had reported from their trip and to talk with them about teaching the children how to cross the street.

Still another agency took part in our training of the career students. We visited Randall House, an outstanding treatment home

for boys, about a mile from the Taylor Homes, which has an elementary schoolroom on the grounds. Part of the purpose of this visit was to show the students the advantages and the limitations of one of the alternate forms of treatment for children who were similar to those we were working with in the Taylor Homes. Our students were very thoughtful about the effects of removing children from their homes, even to such an excellent treatment home as this. They were impressed with the fact that there are few such facilities, and that even for those children who must be placed, the relationships with their families must still be worked out. The visit made them feel hopeful for the small number of children in placement at Randall House, but reinforced their concern with preventive work while children still can be reached in their own homes.

We did not have a research plan built into the program, nor an opportunity to do an objective evaluation. We were geared to service and under pressure of time to use the helping staff while they were available. However, we tried to maintain a professionally self-critical attitude and to learn from our mistakes. We could see improvement in the social functioning of the children and we learned a lot about them that helped us in planning with the school for the next year.

This work was shared and supported by my colleagues at the Central Center and by the administrator, John Sanchez, whose encouragement and confidence in me permitted independent action. My time was freed to expand the program for the next school year in the Beethoven School and to begin a requested consultation program in two more schools. However, no additional professional staff could be spared from our Division, and we needed experienced leaders for the new parents' groups.

I found that the graduate psychology department of a near-by university was seeking placements for their students in group therapy. They assigned two men, doctoral candidates, who had excellent past experience for this work—one Negro and one white. I participated in their supervision and attended their group process class. After completion of their group practicum experience, one of them remained as a volunteer.

Many undergraduate students in sociology, psychology, and education have come to us from four colleges to work as volunteers with children in an after-school program. A sorority pledge group of middle-class Negro college girls became involved in several ways. Some of these young people are considering a career in social work or mental health, and we are contributing informally to their preprofessional education.

Another difficult staff problem was to find consistent care for the preschool children of mothers who could not otherwise attend group meetings. This was solved by a novel circumstance. The PTA of an adjacent district had organized a reading circle in which women prepared themselves to read to preschool children, inspired by the Head Start program of the previous summer. They collected preschool books and were ready to read before the children in their own neighborhoods were organized for this. Thus, they became volunteer readers for our preschoolers until children in their own neighborhoods were available. Several of them, both Negro and white middle-class women, have continued faithfully throughout the year, and some have brought their own preschoolers with them. Recently, with the help of PTA leaders, building council leaders, housing management aides, public assistance workers, and community representatives, we have found a few mothers in Taylor Homes who are ready to read to each other's children. A "graduate" mother of last summer's group is one of the regular volunteers.

I have described a "community mental health service in miniature" in which nonprofessional helpers from many walks of life extended the effectiveness of professional personnel. We saw the helpers (subprofessionals, nonprofessionals, and indigenous leaders), not as second best, not as substitutes for professionals, but as having valued attributes of their own to contribute to the helping process. It may be asked whether the helpers benefited more than those whom they were to help, but this does not seem to me a matter of concern, since, as Gisela Konopka so clearly teaches, all helping is a process that benefits both parties.

I have also indicated how the use of nonprofessionals is related to changes in the job of the professional, in this instance a psychi-

atric social worker whose previous experience was primarily with individual methods of treatment. I felt that all the kinds of work I did were compatible with my image of what a social worker should do.

Some of the methods described can hardly be considered innovations since they come from the oldest traditions in social work. Those who work in group settings, especially in settlement houses, may wonder what about all this is supposed to be new, since their work has long been geared to neighborhood approaches and self-help movements. In fact, one of my most important sources of help has been the report of the 1963 conference, sponsored by the Massachusetts Department of Mental Health, that discussed the mental health role of settlement and community centers.

In any case, whether through new ways or old, innovation or tradition, "revolution" or "bandwagon," and whether we train a new kind of social worker or remake old ones, we have an opportunity to demonstrate a social work tradition that I hope we shall not let ourselves be accused of giving up. Paraphrased from an old saying, it is that "social workers will continue to venture in where angels fear to tread."

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